

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R # 2 Hagerstown</u> 10 yrs. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 2 Hagerstown</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R # 2 Hagerstown</u> d. STREET ADDRESS <u>R # 2 Hagerstown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Gertrude Emma Airesman</u>						4. DATE OF DEATH <u>February 5 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1882</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Flowers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Milford, Kansas</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Henry Bartell</u>						14. MOTHER'S MAIDEN NAME <u>Barbara Faidley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>172-09-5617 A</u>		17. INFORMANT <u>Mr. Harry D. Airesman R # 2 Hagerstown, Md.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Several months</u> 5 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-4-</u> <u>1966</u> , to <u>2-5-</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>2-5-</u> <u>1966</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. G. Host</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
<u>Rest Haven Funeral Chapel</u>						<u>Hagerstown, Md.</u>		DATE <u>FEB 10 1966</u>			

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02868

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
c. LENGTH OF STAY IN lb 1 1/2 MOS.			d. STREET ADDRESS 237 S. MULBERRY STREET		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JAMES Middle DAVID Last ALLEN			4. DATE OF DEATH Month FEBRUARY Day 23 Year 1966		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 4, 1882	9. AGE (in years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MILLER		10b. KIND OF BUSINESS OR INDUSTRY ORGAN FACTORY		11. BIRTHPLACE (County & State, or foreign country) DEANSBORO, N. YORK	
13. FATHER'S NAME WILLIAM ALLEN		14. MOTHER'S MAIDEN NAME MARY BRODIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3049		17. INFORMANT MRS. LOUISE ALLEN	
		237 S. MULBERRY ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinoma of the lung 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2/2 , 1966, to 2/23 , 1966, that (I) (we) last saw the deceased alive on 2/23 , 1966, and that death occurred at 2 AM , from the causes and on the date stated above.					
22a. SIGNATURE Howard N. Weeks			22b. DATE SIGNED 2/23/1966		22c. PHYSICIAN'S NAME (Type) HOWARD N. WEEKS M.D.
22d. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MD.			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
23d. LOCATION (City, town or county) HAGERSTOWN, MARYLAND		(State)			
24. FUNERAL DIRECTOR Charles L. Lough		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 1 1966	
25b. REGISTRAR'S SIGNATURE Charles L. Lough					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02891

02869

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>47 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Cumberland St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>May</u> Last <u>Bain</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/70</u>	
9. AGE (in years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home duties</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clear Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Luther Beard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Feidt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-3752</u>		17. INFORMANT <u>Benjimen Solliday</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia acute</u> <u>443+</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 19 65</u> , <u>Feb. 08</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>February 07 1966</u> , and that death occurred at <u>4:35AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Archie Robert Cohen</u>				22b. DATE SIGNED <u>Feb 09, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. Paul, Wash. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Margaret Rowland</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			

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U.S. DEPT. OF JUSTICE

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Very truly yours,

Respectfully,

John Edgar Hoover

Director

Washington, D.C.

Washington, D.C.

Dear Sir:

Dear Sir:

7/10/10

7/10/10

Very truly yours,

John Edgar Hoover

Director

Very truly yours,

John Edgar Hoover

Washington, D.C.

Washington, D.C.

Very truly yours,

John Edgar Hoover

Director

Very truly yours,

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Very truly yours,

John Edgar Hoover

Director

Washington, D.C.

Washington, D.C.

02892

Item 9 Film 6574 2/28/66 md

CERTIFICATE OF DEATH

02870

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN lb <u>10 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN RURAL 10-2</u>		d. STREET ADDRESS <u>_____</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fahrney Keedy Memorial Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edwin BAKER</u>				4. DATE OF DEATH Month Day Year <u>Feb. 19 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1874</u>	9. AGE (In years last birthday) <u>91 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALLERGY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary T. Case</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MD R2</u> <u>MRS CARROLL WARFIELD, UNION BRIDGE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause } (a), stating the underlying cause last. } DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Feb 10 1966</u> <u>Feb 19 1966</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10 1966</u> to <u>Feb 19 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 18 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Hedman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Boonsboro, Md.</u>		22b. DATE SIGNED <u>2/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Hedman</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GROVE</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK CO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons Libertytown, Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural 1				c. LENGTH OF STAY IN lb 15 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural 1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clear Spring, Md.						d. STREET ADDRESS Clear Spring, Md.				e. IS RESIDENCE ON A FARM? YES [X] NO []	
3. NAME OF DECEASED (Type or print)		First Bernard		Middle Issac		Last Barnhart		4. DATE OF DEATH Feb.		Month Day Year 6, 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED [X] NEVER MARRIED [] WIDOWED [] DIVORCED []		8. DATE OF BIRTH Nov. 15, 1892		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Fulton Co. Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stillwell Barnhart						14. MOTHER'S MAIDEN NAME Elizebeth Mann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None				16. SOCIAL SECURITY NO. 212-38-9154		17. INFORMANT Mrs Lola Barnhart Rd. 1, Clear Spring		Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with general metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO (b) metastases (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work [] Not while at work []		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-19, 1954, to 2-6, 1966, that (I) (we) last saw the deceased alive on 12-6 1965, and that death occurred at 8:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles E. Hess						M.D. ATTENDING PHYS. [X] MEO. DIRECTOR [] STAFF PHYS. []		22b. DATE SIGNED 2-8-66			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/9/66		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION (City, town or county) (State) Broadfording, Md.			
24. FUNERAL DIRECTOR Margaret Rowland				Clear Spring, Md.		25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF BIRTH

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John J. Smith

John J. Smith

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02894

02872

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 13 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 29 High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Clyde Middle Victor Last Barnhart				4. DATE OF DEATH Month February Day 23 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1922		
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 1 Days 8 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (County & State, or foreign country) Millstone, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter H. Barnhart				14. MOTHER'S MAIDEN NAME Daisy Manning				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. Two			16. SOCIAL SECURITY NO. 216- 14- 5756		17. INFORMANT Mrs. Doris H. Barnhart, Address 29 High St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Massive 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Disease DUE TO (c) Nephrosclerosis							INTERVAL BETWEEN ONSET AND DEATH 8 hrs 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 12, 1934 to Feb 23, 1966 , that (I) (we) last saw the deceased alive on Feb 23, 1966 , and that death occurred at 330 PM , from causes and on the date stated above.								
22a. SIGNATURE Robert V. H. Campbell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/25/66		
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell				22d. ADDRESS HAGERSTOWN MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2- 26- 66		23c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Hancock, Wash. Co. Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR FEB 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

158875

OFFICE OF THE SECRETARY

08222

(1)

MEMORANDUM FOR THE SECRETARY

1. The following information was received from the

Department of the Interior

on the subject of the proposed

amendment to the National Monument

and the proposed

amendment to the National Monument

and the proposed

amendment to the National Monument

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CERTIFICATE OF DEATH

028735-4810
 Reg. Dist. No.

02895

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> 21-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>1104 S. POTOMAC ST.</u>			
3. NAME OF DECEASED (Type or print) <u>BABY GIRL BLACK</u> First Middle Last				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 17, 1966</u> yrs.		9. AGE (In years lost birthday) Months <u>17</u> Days <u>19</u> Hours <u>6</u> Min <u>6</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES RICHARD MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>JUDY ANN BLACK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>7699</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prolapsed Cord</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. D. Turco</u> M.D. <u>HAGERSTOWN, MD.</u>				PHYSICIAN'S NAME (Type) <u>DR. J. D. TURCO, HAGERSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/21/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH. Co. Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Schaffer, adm. Wash Co Hosp.</u>				24a. REC'D BY REGISTRAR <u>MAR 4 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

WASHINGTON HAGERSTOWN WASH. COUNTY HOSPITAL 1104 S. POTOMAC ST. HAGERSTOWN, MD. FEBRUARY 17, 1947		WASHINGTON HAGERSTOWN WASH. COUNTY HOSPITAL 1104 S. POTOMAC ST. HAGERSTOWN, MD. FEBRUARY 17, 1947	
FEMALE W. RACE MARYLAND CHARLES RICHARD MARTIN AND JUDY ANN BLACK MOTHER		FEMALE W. RACE MARYLAND CHARLES RICHARD MARTIN AND JUDY ANN BLACK MOTHER	
PREGNANT DELIVERED LIVED DIED STILLBORN		PREGNANT DELIVERED LIVED DIED STILLBORN	
DR. J. D. TURCO, HAGERSTOWN, MD. M. J. MURPHY		DR. J. D. TURCO, HAGERSTOWN, MD. M. J. MURPHY	
HAGERSTOWN, MD. FEBRUARY 17, 1947		HAGERSTOWN, MD. FEBRUARY 17, 1947	

CERTIFICATE OF DEATH

1947

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02896

02874

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 2 MOS.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS 138 N. POTOMAC STREET		
3. NAME OF DECEASED (Type or print) First ROSE Middle ETTA Last SMITH BOLINGER			4. DATE OF DEATH Month FEBRUARY Day 7 Year 1966		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1908	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 7 Days 19 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) CLARKE CO., VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME CHARLES T. ROWLAND		
14. MOTHER'S MAIDEN NAME ANNIE E. MORELAND			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT MRS. WILLIAM HART R.D. # 2 BERRYVILLE, VA.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of esophagus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 mo. 9 mo - 15 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 8-11 , 19 56 to death , 19 66 , that (I) (we) last saw the deceased alive on 2-7 , 19 66 , and that death occurred at 4:30 P. M, from the causes and on the date stated above.					
22a. SIGNATURE Robert F. Keadle			22b. DATE SIGNED 2/8/ 1966		
22c. PHYSICIAN'S NAME (Type) ROBERT F. KEADLE, M.D.			22d. ADDRESS 580 NORTHERN AVE., HAGERSTOWN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 10, 1966		23c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY	
23d. LOCATION (City, town or county) SHARPSBURG, MARYLAND		23e. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR Charles Judge		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR FEB 14 1966	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02897

CERTIFICATE OF DEATH

02875

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		d. STREET ADDRESS <u>101 Council St.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fahrney-Keedy Memorial Home, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Chrisse</u>		First <u>Chrisse</u> Middle <u>Byrd Dell</u> Last <u>BOWERS</u>		4. DATE OF DEATH <u>Feb.</u> Month <u>9</u> Day <u>19</u> Year <u>66</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1875</u>									
9. AGE (In years last birthday) <u>90</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
	Hours														
	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Martin Luther Firestone</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Virginia Galle</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles F. Bowers</u> Address <u>18 West Third St. Fred. Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>8 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1966</u> to <u>Feb 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>1:11</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>G. W. Heelan</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/66</u>									
22c. PHYSICIAN'S NAME (Type) <u>G. W. Heelan</u>				22d. ADDRESS <u>Boonsboro, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>									
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey & Son</u>				ADDRESS <u>Frederick, Maryland</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>FFB 14 1966</u> <u>Charles Judge</u>									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02893

02876

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 69 years		d. STREET ADDRESS 413 Sherwood Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle VIOLA Last BREWER		4. DATE OF DEATH Month February Day 20 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1896
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) general work		10b. KIND OF BUSINESS OR INDUSTRY dept. store	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles E. Slick		14. MOTHER'S MAIDEN NAME Sarah Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-30-8703	
17. INFORMANT Charles E. Brewer, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Arteriosclerotic Cardio. Dis.		INTERVAL BETWEEN ONSET AND DEATH 2 days 1-2 yrs years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension; Obesity.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 June 1966 , to 20 Feb. 1966 , that (I) (we) last saw the deceased alive on 19 Feb. 1966 , and that death occurred at 1A M, from causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 21 Feb. 1966	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD		22d. ADDRESS HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-22-66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE FEB 24 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

052570

REPORT OF DEATH

052570

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE AT DEATH
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE HISTORY
PREVIOUS ILLNESS
HISTORY OF DRUG USE
HISTORY OF ALCOHOL USE
HISTORY OF TOBACCO USE
HISTORY OF OTHER SUBSTANCE USE
HISTORY OF MENTAL ILLNESS
HISTORY OF PHYSICAL ILLNESS
HISTORY OF TRAUMA
HISTORY OF SURGERY
HISTORY OF HOSPITALIZATION
HISTORY OF LONG-TERM CARE
HISTORY OF HOME CARE
HISTORY OF NURSING HOME CARE
HISTORY OF HOSPICE CARE
HISTORY OF PALLIATIVE CARE
HISTORY OF END-OF-LIFE CARE
HISTORY OF OTHER CARE

DATE OF REPORT
REPORTED BY
TITLE
ADDRESS
CITY
STATE
ZIP
COUNTRY
TELEPHONE
FAX
EMAIL
HOMEPAGE
WEBSITE
BLOG
FORUM
CHAT
MMS
SMS
PAGER
CELLPHONE
LANDLINE
CABLE
SATELLITE
RADIO
TELEVISION
INTERNET
OTHER

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
c. LENGTH OF STAY IN lb <u>1</u> minutes		d. STREET ADDRESS <u>24 S. Conococheague Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Taylor's Landing Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Merle Brown</u>		4. DATE OF DEATH <u>Feb. 8 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23 1917</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR <u>11</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Personnel Director Hospital</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V. A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chalres Brown</u>		14. MOTHER'S MAIDEN NAME <u>Effie Pryor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-05-8730</u>	
17. INFORMANT <u>Mr. Charles Brown</u>		Address <u>24 S. Conococheague St. Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Of Chest (Self Inflicted)</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Self inflicted gunshot wound.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:55 p.m. 2-8- 1966</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Taylor's Landing Rt. Sharpsburg, Washington, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>2-9-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 11-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport Maryland</u>	
25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02900					02878				
Item #2 Film #4373 2715100 pg									
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>UNKNOWN</u> b. COUNTY <u>UNKNOWN</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNKNOWN</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MD STATE HOSPITAL</u> <u>1500 PENN. AVE. HAGERSTOWN, MD.</u>					d. STREET ADDRESS <u>UNKNOWN</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u>			First Middle Last <u>BRUNSON</u>		4. DATE OF DEATH <u>FEB.</u>		Month Day Year <u>4</u> <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1915</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MIGRANT LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>ORCHARD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARION CO., S. CAROLINA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GERALD BRUNSON</u>					14. MOTHER'S MAIDEN NAME <u>TINA A. OWENS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. ELOISE BRUNSON, MULLINS, S. CAROLINA</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>4201</u> DUE TO <u>ACUTE CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>YEARS</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 MOS</u> <u>7 MOS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-6-</u> , 19 <u>65</u> , to <u>2-4-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-4-</u> , 19 <u>66</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Eugen A Ramirez</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-4-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>ERREN A. RAMIREZ MD</u>					22d. ADDRESS <u>1500 PENN. AVE., HAGERSTOWN, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE THEREOF <u>FEB. 5, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>MARION CO., S. CAROLINA</u>	
24. FUNERAL DIRECTOR <u>Charles Hoyer</u>					ADDRESS <u>HAGERSTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02901						02879					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			WASHINGTON			a. STATE			MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			HAGERSTOWN			b. COUNTY			WASHINGTON		
c. LENGTH OF STAY IN 1b			50 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
WASHINGTON COUNTY HOSPITAL						917 GUILFORD AVE.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First MIDDLE Last			4. DATE OF DEATH			Month Day Year		
NETTIE			BLANCHE			BUTLER			FEBRUARY 5 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		WHITE				6/20/1880		85 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE				HOME		VIRGINIA			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
CHARLES ALFRED PRINTZ						SARAH JANE JENKINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO				NONE		MRS. BEULAH SNYDER HAGERSTOWN MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pyelonephritis</i> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
										<i>one year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/3, 1966 to 2/5, 1966, that (I) (we) last saw the deceased alive on 2/5, 1966, and that death occurred at 12:19 P.M. from the causes and on the date stated above.											
22a. SIGNATURE						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS		2-7-66			
Donald E. Martin M.D.						418 North Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			2/7/66			REST HAVEN CEM.			HAGERSTOWN MD.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. J. Kerney, Hagerstown, Md.						DATE FEB 10 1966		J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1074 MARSHALL ST.		d. STREET ADDRESS HAGERSTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH		First MAYBELLE		Middle CARBAUGH		Last FEBRUARY		4. DATE OF DEATH 13		Month 19		Day 66		Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/19/1897		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EIMER WALLACE		14. MOTHER'S MAIDEN NAME SARAH MILLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. HARRY W. CARBAUGH		Address HAGERSTOWN MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute antroseptal 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) atherosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 5 days unk. unk.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 Feb 1966 to 13 Feb 1966 , that (I) (we) last saw the deceased alive on 13 Feb 1966 , and that death occurred at 10:20 PM , from the causes and on the date stated above.		22a. SIGNATURE Clovis M. Snyder M.D.		22b. DATE SIGNED 14 Feb-66		22c. PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER, M.D.		22d. ADDRESS 106 N. POTOMAC ST HAGERSTOWN, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/16/66		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/16/66		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.		24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02903 CERTIFICATE OF DEATH 02882

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro c. LENGTH OF STAY IN lb 1 Yr d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reeder Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1378 Salem Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ELIZABETH CLARK		4. DATE OF DEATH Month Day Year Feb 8 1966 19				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14 1872	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George W. Lewis		14. MOTHER'S MAIDEN NAME Elizabeth Null				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Harsh		Address 1378 Salem Ave
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 10 , 19 66 , to Feb 8 , 19 66 , that (I) (we) last saw the deceased alive on Feb 6 , 19 66 , and that death occurred at 6 P M, from the causes and on the date stated above.						
22a. SIGNATURE G W Keenan		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/10/66		
22c. PHYSICIAN'S NAME (Type) G W Keenan		22d. ADDRESS Boonsboro, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-66		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman		ADDRESS Hagerstown Md		25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge

1858

Memorandum for the President

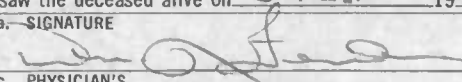
Copy of the report of the
Committee on the
State of the Union
for the year 1858

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
02904 02883												
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN						c. LENGTH OF STAY IN 1b 27 YRS.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 338 E. FRANKLIN STREET						d. STREET ADDRESS 338 E. FRANKLIN STREET						
3. NAME OF DECEASED (Type or print) First NORA Middle LEVINA Last CORRIGAN						4. DATE OF DEATH Month FEBRUARY Day 22 Year 19 66						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1, 1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DANCE INSTR.				10b. KIND OF BUSINESS OR INDUSTRY DANCE SCHOOL		11. BIRTHPLACE (County & State, or foreign country) PASSAIC CO., N. JERSEY			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME PATRICK DUFFY						14. MOTHER'S MAIDEN NAME JULIA KIERNAN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 215-20-9332		17. INFORMANT MRS. JUDY VAUGHN 338 E. FRANKLIN ST.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure & Pulmonary Edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTEROSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH MINUTES MINUTES YEARS												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7 MAY , 19 63 , to 22 FEB , 19 64 , that (I) (we) last saw the deceased alive on 5 FEB. , 19 66 , and that death occurred at 6 AM , from the causes and on the date stated above.												
22a. SIGNATURE 						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/22/1966		
22c. PHYSICIAN'S NAME (Type) WILLIAM N. FENDER						22d. ADDRESS 218 N. POTOMAC ST. HAGERSTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF FEB. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND				
24. FUNERAL DIRECTOR 						ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR FEB 24 1966		25b. REGISTRAR'S SIGNATURE 	

[illegible]

1970-1971 1972-1973 1974-1975 1976-1977 1978-1979 1980-1981 1982-1983 1984-1985 1986-1987 1988-1989 1990-1991 1992-1993 1994-1995 1996-1997 1998-1999 2000-2001 2002-2003 2004-2005 2006-2007 2008-2009 2010-2011 2012-2013 2014-2015 2016-2017 2018-2019 2020-2021 2022-2023 2024-2025 2026-2027 2028-2029 2030-2031 2032-2033 2034-2035 2036-2037 2038-2039 2040-2041 2042-2043 2044-2045 2046-2047 2048-2049 2050-2051 2052-2053 2054-2055 2056-2057 2058-2059 2060-2061 2062-2063 2064-2065 2066-2067 2068-2069 2070-2071 2072-2073 2074-2075 2076-2077 2078-2079 2080-2081 2082-2083 2084-2085 2086-2087 2088-2089 2090-2091 2092-2093 2094-2095 2096-2097 2098-2099 2100-2101 2102-2103 2104-2105 2106-2107 2108-2109 2110-2111 2112-2113 2114-2115 2116-2117 2118-2119 2120-2121 2122-2123 2124-2125 2126-2127 2128-2129 2130-2131 2132-2133 2134-2135 2136-2137 2138-2139 2140-2141 2142-2143 2144-2145 2146-2147 2148-2149 2150-2151 2152-2153 2154-2155 2156-2157 2158-2159 2160-2161 2162-2163 2164-2165 2166-2167 2168-2169 2170-2171 2172-2173 2174-2175 2176-2177 2178-2179 2180-2181 2182-2183 2184-2185 2186-2187 2188-2189 2190-2191 2192-2193 2194-2195 2196-2197 2198-2199 2200-2201 2202-2203 2204-2205 2206-2207 2208-2209 2210-2211 2212-2213 2214-2215 2216-2217 2218-2219 2220-2221 2222-2223 2224-2225 2226-2227 2228-2229 2230-2231 2232-2233 2234-2235 2236-2237 2238-2239 2240-2241 2242-2243 2244-2245 2246-2247 2248-2249 2250-2251 2252-2253 2254-2255 2256-2257 2258-2259 2260-2261 2262-2263 2264-2265 2266-2267 2268-2269 2270-2271 2272-2273 2274-2275 2276-2277 2278-2279 2280-2281 2282-2283 2284-2285 2286-2287 2288-2289 2290-2291 2292-2293 2294-2295 2296-2297 2298-2299 2300-2301 2302-2303 2304-2305 2306-2307 2308-2309 2310-2311 2312-2313 2314-2315 2316-2317 2318-2319 2320-2321 2322-2323 2324-2325 2326-2327 2328-2329 2330-2331 2332-2333 2334-2335 2336-2337 2338-2339 2340-2341 2342-2343 2344-2345 2346-2347 2348-2349 2350-2351 2352-2353 2354-2355 2356-2357 2358-2359 2360-2361 2362-2363 2364-2365 2366-2367 2368-2369 2370-2371 2372-2373 2374-2375 2376-2377 2378-2379 2380-2381 2382-2383 2384-2385 2386-2387 2388-2389 2390-2391 2392-2393 2394-2395 2396-2397 2398-2399 2400-2401 2402-2403 2404-2405 2406-2407 2408-2409 2410-2411 2412-2413 2414-2415 2416-2417 2418-2419 2420-2421 2422-2423 2424-2425 2426-2427 2428-2429 2430-2431 2432-2433 2434-2435 2436-2437 2438-2439 2440-2441 2442-2443 2444-2445 2446-2447 2448-2449 2450-2451 2452-2453 2454-2455 2456-2457 2458-2459 2460-2461 2462-2463 2464-2465 2466-2467 2468-2469 2470-2471 2472-2473 2474-2475 2476-2477 2478-2479 2480-2481 2482-2483 2484-2485 2486-2487 2488-2489 2490-2491 2492-2493 2494-2495 2496-2497 2498-2499 2500-2501 2502-2503 2504-2505 2506-2507 2508-2509 2510-2511 2512-2513 2514-2515 2516-2517 2518-2519 2520-2521 2522-2523 2524-2525 2526-2527 2528-2529 2530-2531 2532-2533 2534-2535 2536-2537 2538-2539 2540-2541 2542-2543 2544-2545 2546-2547 2548-2549 2550-2551 2552-2553 2554-2555 2556-2557 2558-2559 2560-2561 2562-2563 2564-2565 2566-2567 2568-2569 2570-2571 2572-2573 2574-2575 2576-2577 2578-2579 2580-2581 2582-2583 2584-2585 2586-2587 2588-2589 2590-2591 2592-2593 2594-2595 2596-2597 2598-2599 2600-2601 2602-2603 2604-2605 2606-2607 2608-2609 2610-2611 2612-2613 2614-2615 2616-2617 2618-2619 2620-2621 2622-2623 2624-2625 2626-2627 2628-2629 2630-2631 2632-2633 2634-2635 2636-2637 2638-2639 2640-2641 2642-2643 2644-2645 2646-2647 2648-2649 2650-2651 2652-2653 2654-2655 2656-2657 2658-2659 2660-2661 2662-2663 2664-2665 2666-2667 2668-2669 2670-2671 2672-2673 2674-2675 2676-2677 2678-2679 2680-2681 2682-2683 2684-2685 2686-2687 2688-2689 2690-2691 2692-2693 2694-2695 2696-2697 2698-2699 2700-2701 2702-2703 2704-2705 2706-2707 2708-2709 2710-2711 2712-2713 2714-2715 2716-2717 2718-2719 2720-2721 2722-2723 2724-2725 2726-2727 2728-2729 2730-2731 2732-2733 2734-2735 2736-2737 2738-2739 2740-2741 2742-2743 2744-2745 2746-2747 2748-2749 2750-2751 2752-2753 2754-2755 2756-2757 2758-2759 2760-2761 2762-2763 2764-2765 2766-2767 2768-2769 2770-2771 2772-2773 2774-2775 2776-2777 2778-2779 2780-2781 2782-2783 2784-2785 2786-2787 2788

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02905

02884

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>112 Clarkson Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Malinda</u> Middle <u>Crawley</u> Last <u>Crawley</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1 1887</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF FUNER 1 YEAR Months <u>10</u> Days <u>26</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Halifax Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Halifax Co. Virginia</u>	
13. FATHER'S NAME <u>Jacob Adams</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Mc Gee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-16-9203</u>		17. INFORMANT <u>112 Clarkson Ave.</u> <u>Mar. Virginia Bullard Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of Breast</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dietary malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/23, 1964</u> , to <u>2/27, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/27, 1966</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edson B. Moody</u>				22b. DATE SIGNED M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody M.D.</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport, Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

FOR THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02906

02885

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>17 years</u>				d. STREET ADDRESS <u>745 Spruce St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>745 Spruce St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES CATHERINE CURRY</u>				4. DATE OF DEATH Month Day Year <u>Feb 6 1966 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24 1882</u>	
9. AGE (in years last birthday) <u>83 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Linden Warren Co Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Sealock</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-09-7740</u>		17. INFORMANT <u>Mrs Elsie Kump</u>		Address <u>745 Spruce St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>Years</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 1965</u> , to <u>6 Feb 1966</u> , that (I) (we) last saw the deceased alive on <u>3 Feb 1966</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Wilson</u>				22b. DATE SIGNED <u>2/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>J. Wilson</u>	
22d. ADDRESS <u>M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

12/8/50

12/30/50

12/30/50

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro Pa.</u>				d. STREET ADDRESS <u>23 Barnett Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lulu</u> Middle <u>Corbett</u> Last <u>Decker</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/7/1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Corbett</u>						14. MOTHER'S MAIDEN NAME <u>Christina Waugaman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Cyrus M. Corbett</u>				Address <u>23 Barnett Ave. Waynesboro Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1966</u> to <u>Feb 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 11, 1966</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles C. Spencer</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-12-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>						22d. ADDRESS <u>143 S. Prospect ST.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u>				23d. LOCATION (City, town or county) (State) <u>Waynesboro, Franklin Co., Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter J. Grove</u>						ADDRESS <u>Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ¹ ² ³ ⁴ ⁵ ⁶ ⁷ ⁸ ⁹ ¹⁰ ¹¹ ¹² ¹³ ¹⁴ ¹⁵ ¹⁶ ¹⁷ ¹⁸ ¹⁹ ²⁰ ²¹ ²² ²³ ²⁴ ²⁵ ²⁶ ²⁷ ²⁸ ²⁹ ³⁰ ³¹ ³² ³³ ³⁴ ³⁵ ³⁶ ³⁷ ³⁸ ³⁹ ⁴⁰ ⁴¹ ⁴² ⁴³ ⁴⁴ ⁴⁵ ⁴⁶ ⁴⁷ ⁴⁸ ⁴⁹ ⁵⁰ ⁵¹ ⁵² ⁵³ ⁵⁴ ⁵⁵ ⁵⁶ ⁵⁷ ⁵⁸ ⁵⁹ ⁶⁰ ⁶¹ ⁶² ⁶³ ⁶⁴ ⁶⁵ ⁶⁶ ⁶⁷ ⁶⁸ ⁶⁹ ⁷⁰ ⁷¹ ⁷² ⁷³ ⁷⁴ ⁷⁵ ⁷⁶ ⁷⁷ ⁷⁸ ⁷⁹ ⁸⁰ ⁸¹ ⁸² ⁸³ ⁸⁴ ⁸⁵ ⁸⁶ ⁸⁷ ⁸⁸ ⁸⁹ ⁹⁰ ⁹¹ ⁹² ⁹³ ⁹⁴ ⁹⁵ ⁹⁶ ⁹⁷ ⁹⁸ ⁹⁹ ¹⁰⁰ ¹⁰¹ ¹⁰² ¹⁰³ ¹⁰⁴ ¹⁰⁵ ¹⁰⁶ ¹⁰⁷ ¹⁰⁸ ¹⁰⁹ ¹¹⁰ ¹¹¹ ¹¹² ¹¹³ ¹¹⁴ ¹¹⁵ ¹¹⁶ ¹¹⁷ ¹¹⁸ ¹¹⁹ ¹²⁰ ¹²¹ ¹²² ¹²³ ¹²⁴ ¹²⁵ ¹²⁶ ¹²⁷ ¹²⁸ ¹²⁹ ¹³⁰ ¹³¹ ¹³² ¹³³ ¹³⁴ ¹³⁵ ¹³⁶ ¹³⁷ ¹³⁸ ¹³⁹ ¹⁴⁰ ¹⁴¹ ¹⁴² ¹⁴³ ¹⁴⁴ ¹⁴⁵ ¹⁴⁶ ¹⁴⁷ ¹⁴⁸ ¹⁴⁹ ¹⁵⁰ ¹⁵¹ ¹⁵² ¹⁵³ ¹⁵⁴ ¹⁵⁵ ¹⁵⁶ ¹⁵⁷ ¹⁵⁸ ¹⁵⁹ ¹⁶⁰ ¹⁶¹ ¹⁶² ¹⁶³ ¹⁶⁴ ¹⁶⁵ ¹⁶⁶ ¹⁶⁷ ¹⁶⁸ ¹⁶⁹ ¹⁷⁰ ¹⁷¹ ¹⁷² ¹⁷³ ¹⁷⁴ ¹⁷⁵ ¹⁷⁶ ¹⁷⁷ ¹⁷⁸ ¹⁷⁹ ¹⁸⁰ ¹⁸¹ ¹⁸² ¹⁸³ ¹⁸⁴ ¹⁸⁵ ¹⁸⁶ ¹⁸⁷ ¹⁸⁸ ¹⁸⁹ ¹⁹⁰ ¹⁹¹ ¹⁹² ¹⁹³ ¹⁹⁴ ¹⁹⁵ ¹⁹⁶ ¹⁹⁷ ¹⁹⁸ ¹⁹⁹ ²⁰⁰ ²⁰¹ ²⁰² ²⁰³ ²⁰⁴ ²⁰⁵ ²⁰⁶ ²⁰⁷ ²⁰⁸ ²⁰⁹ ²¹⁰ ²¹¹ ²¹² ²¹³ ²¹⁴ ²¹⁵ ²¹⁶ ²¹⁷ ²¹⁸ ²¹⁹ ²²⁰ ²²¹ ²²² ²²³ ²²⁴ ²²⁵ ²²⁶ ²²⁷ ²²⁸ ²²⁹ ²³⁰ ²³¹ ²³² ²³³ ²³⁴ ²³⁵ ²³⁶ ²³⁷ ²³⁸ ²³⁹ ²⁴⁰ ²⁴¹ ²⁴² ²⁴³ ²⁴⁴ ²⁴⁵ ²⁴⁶ ²⁴⁷ ²⁴⁸ ²⁴⁹ ²⁵⁰ ²⁵¹ ²⁵² ²⁵³ ²⁵⁴ ²⁵⁵ ²⁵⁶ ²⁵⁷ ²⁵⁸ ²⁵⁹ ²⁶⁰ ²⁶¹ ²⁶² ²⁶³ ²⁶⁴ ²⁶⁵ ²⁶⁶ ²⁶⁷ ²⁶⁸ ²⁶⁹ ²⁷⁰ ²⁷¹ ²⁷² ²⁷³ ²⁷⁴ ²⁷⁵ ²⁷⁶ ²⁷⁷ ²⁷⁸ ²⁷⁹ ²⁸⁰ ²⁸¹ ²⁸² ²⁸³ ²⁸⁴ ²⁸⁵ ²⁸⁶ ²⁸⁷ ²⁸⁸ ²⁸⁹ ²⁹⁰ ²⁹¹ ²⁹² ²⁹³ ²⁹⁴ ²⁹⁵ ²⁹⁶ ²⁹⁷ ²⁹⁸ ²⁹⁹ ³⁰⁰ ³⁰¹ ³⁰² ³⁰³ ³⁰⁴ ³⁰⁵ ³⁰⁶ ³⁰⁷ ³⁰⁸ ³⁰⁹ ³¹⁰ ³¹¹ ³¹² ³¹³ ³¹⁴ ³¹⁵ ³¹⁶ ³¹⁷ ³¹⁸ ³¹⁹ ³²⁰ ³²¹ ³²² ³²³ ³²⁴ ³²⁵ ³²⁶ ³²⁷ ³²⁸ ³²⁹ ³³⁰ ³³¹ ³³² ³³³ ³³⁴ ³³⁵ ³³⁶ ³³⁷ ³³⁸ ³³⁹ ³⁴⁰ ³⁴¹ ³⁴² ³⁴³ ³⁴⁴ ³⁴⁵ ³⁴⁶ ³⁴⁷ ³⁴⁸ ³⁴⁹ ³⁵⁰ ³⁵¹ ³⁵² ³⁵³ ³⁵⁴ ³⁵⁵ ³⁵⁶ ³⁵⁷ ³⁵⁸ ³⁵⁹ ³⁶⁰ ³⁶¹ ³⁶² ³⁶³ ³⁶⁴ ³⁶⁵ ³⁶⁶ ³⁶⁷ ³⁶⁸ ³⁶⁹ ³⁷⁰ ³⁷¹ ³⁷² ³⁷³ ³⁷⁴ ³⁷⁵ ³⁷⁶ ³⁷⁷ ³⁷⁸ ³⁷⁹ ³⁸⁰ ³⁸¹ ³⁸² ³⁸³ ³⁸⁴ ³⁸⁵ ³⁸⁶ ³⁸⁷ ³⁸⁸ ³⁸⁹ ³⁹⁰ ³⁹¹ ³⁹² ³⁹³ ³⁹⁴ ³⁹⁵ ³⁹⁶ ³⁹⁷ ³⁹⁸ ³⁹⁹ ⁴⁰⁰ ⁴⁰¹ ⁴⁰² ⁴⁰³ ⁴⁰⁴ ⁴⁰⁵ ⁴⁰⁶ ⁴⁰⁷ ⁴⁰⁸ ⁴⁰⁹ ⁴¹⁰ ⁴¹¹ ⁴¹² ⁴¹³ ⁴¹⁴ ⁴¹⁵ ⁴¹⁶ ⁴¹⁷ ⁴¹⁸ ⁴¹⁹ ⁴²⁰ ⁴²¹ ⁴²² ⁴²³ ⁴²⁴ ⁴²⁵ ⁴²⁶ ⁴²⁷ ⁴²⁸ ⁴²⁹ ⁴³⁰ ⁴³¹ ⁴³² ⁴³³ ⁴³⁴ ⁴³⁵ ⁴³⁶ ⁴³⁷ ⁴³⁸ ⁴³⁹ ⁴⁴⁰ ⁴⁴¹ ⁴⁴² ⁴⁴³ ⁴⁴⁴ ⁴⁴⁵ ⁴⁴⁶ ⁴⁴⁷ ⁴⁴⁸ ⁴⁴⁹ ⁴⁵⁰ ⁴⁵¹ ⁴⁵² ⁴⁵³ ⁴⁵⁴ ⁴⁵⁵ ⁴⁵⁶ ⁴⁵⁷ ⁴⁵⁸ ⁴⁵⁹ ⁴⁶⁰ ⁴⁶¹ ⁴⁶² ⁴⁶³ ⁴⁶⁴ ⁴⁶⁵ ⁴⁶⁶ ⁴⁶⁷ ⁴⁶⁸ ⁴⁶⁹ ⁴⁷⁰ ⁴⁷¹ ⁴⁷² ⁴⁷³ ⁴⁷⁴ ⁴⁷⁵ ⁴⁷⁶ ⁴⁷⁷ ⁴⁷⁸ ⁴⁷⁹ ⁴⁸⁰ ⁴⁸¹ ⁴⁸² ⁴⁸³ ⁴⁸⁴ ⁴⁸⁵ ⁴⁸⁶ ⁴⁸⁷ ⁴⁸⁸ ⁴⁸⁹ ⁴⁹⁰ ⁴⁹¹ ⁴⁹² ⁴⁹³ ⁴⁹⁴ ⁴⁹⁵ ⁴⁹⁶ ⁴⁹⁷ ⁴⁹⁸ ⁴⁹⁹ ⁵⁰⁰ ⁵⁰¹ ⁵⁰² ⁵⁰³ ⁵⁰⁴ ⁵⁰⁵ ⁵⁰⁶ ⁵⁰⁷ ⁵⁰⁸ ⁵⁰⁹ ⁵¹⁰ ⁵¹¹ ⁵¹² ⁵¹³ ⁵¹⁴ ⁵¹⁵ ⁵¹⁶ ⁵¹⁷ ⁵¹⁸ ⁵¹⁹ ⁵²⁰ ⁵²¹ ⁵²² ⁵²³ ⁵²⁴ ⁵²⁵ ⁵²⁶ ⁵²⁷ ⁵²⁸ ⁵²⁹ ⁵³⁰ ⁵³¹ ⁵³² ⁵³³ ⁵³⁴ ⁵³⁵ ⁵³⁶ ⁵³⁷ ⁵³⁸ ⁵³⁹ ⁵⁴⁰ ⁵⁴¹ ⁵⁴² ⁵⁴³ ⁵⁴⁴ ⁵⁴⁵ ⁵⁴⁶ ⁵⁴⁷ ⁵⁴⁸ ⁵⁴⁹ ⁵⁵⁰ ⁵⁵¹ ⁵⁵² ⁵⁵³ ⁵⁵⁴ ⁵⁵⁵ ⁵⁵⁶ ⁵⁵⁷ ⁵⁵⁸ ⁵⁵⁹ ⁵⁶⁰ ⁵⁶¹ ⁵⁶² ⁵⁶³ ⁵⁶⁴ ⁵⁶⁵ ⁵⁶⁶ ⁵⁶⁷ ⁵⁶⁸ ⁵⁶⁹ ⁵⁷⁰ ⁵⁷¹ ⁵⁷² ⁵⁷³ ⁵⁷⁴ ⁵⁷⁵ ⁵⁷⁶ ⁵⁷⁷ ⁵⁷⁸ ⁵⁷⁹ ⁵⁸⁰ ⁵⁸¹ ⁵⁸² ⁵⁸³ ⁵⁸⁴ ⁵⁸⁵ ⁵⁸⁶ ⁵⁸⁷ ⁵⁸⁸ ⁵⁸⁹ ⁵⁹⁰ ⁵⁹¹ ⁵⁹² ⁵⁹³ ⁵⁹⁴ ⁵⁹⁵ ⁵⁹⁶ ⁵⁹⁷ ⁵⁹⁸ ⁵⁹⁹ ⁶⁰⁰ ⁶⁰¹ ⁶⁰² ⁶⁰³ ⁶⁰⁴ ⁶⁰⁵ ⁶⁰⁶ ⁶⁰⁷ ⁶⁰⁸ ⁶⁰⁹ ⁶¹⁰ ⁶¹¹ ⁶¹² ⁶¹³ ⁶¹⁴ ⁶¹⁵ ⁶¹⁶ ⁶¹⁷ ⁶¹⁸ ⁶¹⁹ ⁶²⁰ ⁶²¹ ⁶²² ⁶²³ ⁶²⁴ ⁶²⁵ ⁶²⁶ ⁶²⁷ ⁶²⁸ ⁶²⁹ ⁶³⁰ ⁶³¹ ⁶³² ⁶³³ ⁶³⁴ ⁶³⁵ ⁶³⁶ ⁶³⁷ ⁶³⁸ ⁶³⁹ ⁶⁴⁰ ⁶⁴¹ ⁶⁴² ⁶⁴³ ⁶⁴⁴ ⁶⁴⁵ ⁶⁴⁶ ⁶⁴⁷ ⁶⁴⁸ ⁶⁴⁹ ⁶⁵⁰ ⁶⁵¹ ⁶⁵² ⁶⁵³ ⁶⁵⁴ ⁶⁵⁵ ⁶⁵⁶ ⁶⁵⁷ ⁶⁵⁸ ⁶⁵⁹ ⁶⁶⁰ ⁶⁶¹ ⁶⁶² ⁶⁶³ ⁶⁶⁴ ⁶⁶⁵ ⁶⁶⁶ ⁶⁶⁷ ⁶⁶⁸ ⁶⁶⁹ ⁶⁷⁰ ⁶⁷¹ ⁶⁷² ⁶⁷³ ⁶⁷⁴ ⁶⁷⁵ ⁶⁷⁶ ⁶⁷⁷ ⁶⁷⁸ ⁶⁷⁹ ⁶⁸⁰ ⁶⁸¹ ⁶⁸² ⁶⁸³ ⁶⁸⁴ ⁶⁸⁵ ⁶⁸⁶ ⁶⁸⁷ ⁶⁸⁸ ⁶⁸⁹ ⁶⁹⁰ ⁶⁹¹ ⁶⁹² ⁶⁹³ ⁶⁹⁴ ⁶⁹⁵ ⁶⁹⁶ ⁶⁹⁷ ⁶⁹⁸ ⁶⁹⁹ ⁷⁰⁰ ⁷⁰¹ ⁷⁰² ⁷⁰³ ⁷⁰⁴ ⁷⁰⁵ ⁷⁰⁶ ⁷⁰⁷ ⁷⁰⁸ ⁷⁰⁹ ⁷¹⁰ ⁷¹¹ ⁷¹² ⁷¹³ ⁷¹⁴ ⁷¹⁵ ⁷¹⁶ ⁷¹⁷ ⁷¹⁸ ⁷¹⁹ ⁷²⁰ ⁷²¹ ⁷²² ⁷²³ ⁷²⁴ ⁷²⁵ ⁷²⁶ ⁷²⁷ ⁷²⁸ ⁷²⁹ ⁷³⁰ ⁷³¹ ⁷³² ⁷³³ ⁷³⁴ ⁷³⁵ ⁷³⁶ ⁷³⁷ ⁷³⁸ ⁷³⁹ ⁷⁴⁰ ⁷⁴¹ ⁷⁴² ⁷⁴³ ⁷⁴⁴ ⁷⁴⁵ ⁷⁴⁶ ⁷⁴⁷ ⁷⁴⁸ ⁷⁴⁹ ⁷⁵⁰ ⁷⁵¹ ⁷⁵² ⁷⁵³ ⁷⁵⁴ ⁷⁵⁵ ⁷⁵⁶ ⁷⁵⁷ ⁷⁵⁸ ⁷⁵⁹ ⁷⁶⁰ ⁷⁶¹ ⁷⁶² ⁷⁶³ ⁷⁶⁴ ⁷⁶⁵ ⁷⁶⁶ ⁷⁶⁷ ⁷⁶⁸ ⁷⁶⁹ ⁷⁷⁰ ⁷⁷¹ ⁷⁷² ⁷⁷³ ⁷⁷⁴ ⁷⁷⁵ ⁷⁷⁶ ⁷⁷⁷ ⁷⁷⁸ ⁷⁷⁹ ⁷⁸⁰ ⁷⁸¹ ⁷⁸² ⁷⁸³ ⁷⁸⁴ ⁷⁸⁵ ⁷⁸⁶ ⁷⁸⁷ ⁷⁸⁸ ⁷⁸⁹ ⁷⁹⁰ ⁷⁹¹ ⁷⁹² ⁷⁹³ ⁷⁹⁴ ⁷⁹⁵ ⁷⁹⁶ ⁷⁹⁷ ⁷⁹⁸ ⁷⁹⁹ ⁸⁰⁰ ⁸⁰¹ ⁸⁰² ⁸⁰³ ⁸⁰⁴ ⁸⁰⁵ ⁸⁰⁶ ⁸⁰⁷ ⁸⁰⁸ ⁸⁰⁹ ⁸¹⁰ ⁸¹¹ ⁸¹² ⁸¹³ ⁸¹⁴ ⁸¹⁵ ⁸¹⁶ ⁸¹⁷ ⁸¹⁸ ⁸¹⁹ ⁸²⁰ ⁸²¹ ⁸²² ⁸²³ ⁸²⁴ ⁸²⁵ ⁸²⁶ ⁸²⁷ ⁸²⁸ ⁸²⁹ ⁸³⁰ ⁸³¹ ⁸³² ⁸³³ ⁸³⁴ ⁸³⁵ ⁸³⁶ ⁸³⁷ ⁸³⁸ ⁸³⁹ ⁸⁴⁰ ⁸⁴¹ ⁸⁴² ⁸⁴³ ⁸⁴⁴ ⁸⁴⁵ ⁸⁴⁶ ⁸⁴⁷ ⁸⁴⁸ ⁸⁴⁹ ⁸⁵⁰ ⁸⁵¹ ⁸⁵² ⁸⁵³ ⁸⁵⁴ ⁸⁵⁵ ⁸⁵⁶ ⁸⁵⁷ ⁸⁵⁸ ⁸⁵⁹ ⁸⁶⁰ ⁸⁶¹ ⁸⁶² ⁸⁶³ ⁸⁶⁴ ⁸⁶⁵ ⁸⁶⁶ ⁸⁶⁷ ⁸⁶⁸ ⁸⁶⁹ ⁸⁷⁰ ⁸⁷¹ ⁸⁷² ⁸⁷³ ⁸⁷⁴ ⁸⁷⁵ ⁸⁷⁶ ⁸⁷⁷ ⁸⁷⁸ ⁸⁷⁹ ⁸⁸⁰ ⁸⁸¹ ⁸⁸² ⁸⁸³ ⁸⁸⁴ ⁸⁸⁵ ⁸⁸⁶ ⁸⁸⁷ ⁸⁸⁸ ⁸⁸⁹ ⁸⁹⁰ ⁸⁹¹ ⁸⁹² ⁸⁹³ ⁸⁹⁴ ⁸⁹⁵ ⁸⁹⁶ ⁸⁹⁷ ⁸⁹⁸ ⁸⁹⁹ ⁹⁰⁰ ⁹⁰¹ ⁹⁰² ⁹⁰³ ⁹⁰⁴ ⁹⁰⁵ ⁹⁰⁶ ⁹⁰⁷ ⁹⁰⁸ ⁹⁰⁹ ⁹¹⁰ ⁹¹¹ ⁹¹² ⁹¹³ ⁹¹⁴ ⁹¹⁵ ⁹¹⁶ ⁹¹⁷ ⁹¹⁸ ⁹¹⁹ ⁹²⁰ ⁹²¹ ⁹²² ⁹²³ ⁹²⁴ ⁹²⁵ ⁹²⁶ ⁹²⁷ ⁹²⁸ ⁹²⁹ ⁹³⁰ ⁹³¹ ⁹³² ⁹³³ ⁹³⁴ ⁹³⁵ ⁹³⁶ ⁹³⁷ ⁹³⁸ ⁹³⁹ ⁹⁴⁰ ⁹⁴¹ ⁹⁴² ⁹⁴³ ⁹⁴⁴ ⁹⁴⁵ ⁹⁴⁶ ⁹⁴⁷ ⁹⁴⁸ ⁹⁴⁹ ⁹⁵⁰ ⁹⁵¹ ⁹⁵² ⁹⁵³ ⁹⁵⁴ ⁹⁵⁵ ⁹⁵⁶ ⁹⁵⁷ ⁹⁵⁸ ⁹⁵⁹ ⁹⁶⁰ ⁹⁶¹ ⁹⁶² ⁹⁶³ ⁹⁶⁴ ⁹⁶⁵ ⁹⁶⁶ ⁹⁶⁷ ⁹⁶⁸ ⁹⁶⁹ ⁹⁷⁰ ⁹⁷¹ ⁹⁷² ⁹⁷³ ⁹⁷⁴ ⁹⁷⁵ ⁹⁷⁶ ⁹⁷⁷ ⁹⁷⁸ ⁹⁷⁹ ⁹⁸⁰ ⁹⁸¹ ⁹⁸² ⁹⁸³ ⁹⁸⁴ ⁹⁸⁵ ⁹⁸⁶ ⁹⁸⁷ ⁹⁸⁸ ⁹⁸⁹ ⁹⁹⁰ ⁹⁹¹ ⁹⁹² ⁹⁹³ ⁹⁹⁴ ⁹⁹⁵ ⁹⁹⁶ ⁹⁹⁷ ⁹⁹⁸ ⁹⁹⁹ ¹⁰⁰⁰

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport R #1		c. LENGTH OF STAY IN 1b 83 Yrs		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport R #1		d. STREET ADDRESS Dellinger Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First		Middle SUSAN		Last DELLINGER		4. DATE OF DEATH Feby 2 1966		Month 19		Day 19		Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH Aug 29 1882		9. AGE (In years last birthday) 83		yrs.		10. IF UNDER 1 YEAR Months 31		Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lewis Rhodes		14. MOTHER'S MAIDEN NAME Sarah Forthman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lewis H. Dellinger Williamsport		Address R. # 1 Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Jan 31 - 1966		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 31 , 1966, to Feb 2 , 1966, that (I) (we) last saw the deceased alive on Jan 1 , 1966, and that death occurred at 1 P M, from the causes and on the date stated above.		22a. SIGNATURE Sidney Hovener		M.D. SIDNEY HOVENER		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-4-66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/66		23c. NAME OF CEMETERY OR CREMATORY Lutheren Cemetery		23d. LOCATION (City, town or county) Bakersville Wash Co Md		25a. REC'D BY REGISTRAR FEB 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		Address Ragerstown Md.		25c. REGISTRAR'S SIGNATURE Charles Judge											

Charles H. Henshaw
Cotton

John W. Henshaw
Cotton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02909

02888

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN ID 8 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 447 W. WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEANETTE Middle ESTELLA Last EDMOND		4. DATE OF DEATH Month FEBRUARY Day 19 Year 1966	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12/21/1921 9. AGE (in years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY HOME 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH H. F. MARTIN		14. MOTHER'S MAIDEN NAME VIRGIE B. ALEXANDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NADENE GRAIL 17. INFORMANT BALTIMORE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio vas. C. 11/19/66 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis Liver DUE TO (c) Hepatocellular Dis. Liver		INTERVAL BETWEEN ONSET AND DEATH 11/19/66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/66 , 19 66 , to 2/14/66 , 19 66 , that (I) (we) last saw the deceased alive on 2/14/66 , 19 66 , and that death occurred at 2-14-66 M, from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Grier 22a. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 2-14-66 22b. ADDRESS 500 North Ave HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/22/66	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR W. J. Hornum, Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 24 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02510

02889

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">Washington MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY <div style="text-align: center;">Maryland Washington</div>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Hagerstown</div>			c. LENGTH OF STAY IN 1b <div style="text-align: center;">23 Yrs</div>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Hagerstown</div>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">1028 Potomac Ave</div>				d. STREET ADDRESS <div style="text-align: center;">1028 Potomac Ave</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">HANNA LYON EINBINDER</div>				4. DATE OF DEATH <div style="text-align: center;">Feby 8 1966 19</div>		5. SEX <div style="text-align: center;">Female</div>			
6. COLOR OR RACE <div style="text-align: center;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center;">Sept 16 1883</div>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <div style="text-align: center;">83 yrs. Months Days Hours Min.</div>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Housewife</div>			10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Own Home</div>		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">Hagerstown Wash Co Md.</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">USA</div>		
13. FATHER'S NAME <div style="text-align: center;">Moses Lyon</div>				14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Rosa Nachimson</div>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">-----</div>		17. INFORMANT Address <div style="text-align: center;">Irving M. Einbinder 42 No Jonathan</div>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="text-align: center;">Hagerstown Md.</div>								INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">2-3 yrs</div>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leiomycosarcoma of Stomach</i> <div style="text-align: center;">151X</div>									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-9-58</i> , 19 <i>58</i> , to <i>2-8</i> , 19 <i>66</i> , that (I) (this hospital) last saw the deceased alive on <i>2-8</i> , 19 <i>66</i> , and that death occurred at <i>11:49</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <div style="text-align: center;">Dalton M. Welty, M.D.</div>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <div style="text-align: center;">2-8-66</div>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <div style="text-align: center;">998 Potomac Ave., Hagerstown, Md.</div>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		23b. DATE THEREOF <div style="text-align: center;">2-9-66</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">B'Nai Abraham Cemetery</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center;">Halfway Wash Co Md</div>			
24. FUNERAL DIRECTOR <div style="text-align: center;">Andrew K. Coffman Funeral Home Inc</div>				25a. REC'D BY REGISTRAR <div style="text-align: center;">FEB 14 1966</div>		25b. REGISTRAR'S SIGNATURE <div style="text-align: center;">Charles Judge</div>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if an event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02911

CERTIFICATE OF DEATH

02890

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 68 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Manor Nursing Home		d. STREET ADDRESS 120 Bower Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle LENA Last EVERHART		4. DATE OF DEATH Month February Day 22 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1884
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Page, Co. Va.		12. CITIZEN OF WHAT COUNTRY? Page, Co. Va.	
13. FATHER'S NAME George Louderbach		14. MOTHER'S MAIDEN NAME Mary unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Edward Pearman		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis. DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1966 , to Feb 22, 1966 , that (I) (we) last saw the deceased alive on Feb 22, 1966 , and that death occurred at 3:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE J. H. Beasley M.D.		22b. DATE SIGNED Feb. 24/66	
22c. PHYSICIAN'S NAME (Type) J. H. Beasley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

02830

CERTIFICATE OF DEATH

02831



1. Name of Deceased: [Illegible]

2. Date of Death: [Illegible]

3. Place of Death: [Illegible]

4. Cause of Death: [Illegible]

5. Signature of Physician: [Illegible]

6. Signature of Registrar: [Illegible]

7. Date of Registration: [Illegible]

8. Place of Registration: [Illegible]

9. Name of Registrar: [Illegible]

10. Signature of Deceased: [Illegible]

11. Signature of Next of Kin: [Illegible]

12. Signature of Minister: [Illegible]

13. Signature of Burial: [Illegible]

14. Signature of Interment: [Illegible]

15. Signature of Burial: [Illegible]

16. Signature of Interment: [Illegible]

17. Signature of Burial: [Illegible]

18. Signature of Interment: [Illegible]

19. Signature of Burial: [Illegible]

20. Signature of Interment: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
02912					CERTIFICATE OF DEATH					02891									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b UNKNOWN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CLEARVIEW NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY FRANKLIN c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHAMBERSBURG d. STREET ADDRESS 937 WILSON AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First CHARLES Middle EUGENE Last FISLER					4. DATE OF DEATH Month FEBRUARY Day 4 Year 19 66														
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 2, 1875		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIMEKEEPER					10b. KIND OF BUSINESS OR INDUSTRY MANUF. CO.					11. BIRTHPLACE (County & State, or foreign country) FRANKLIN CO. PENNA.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME DAVID B. FISLER					14. MOTHER'S MAIDEN NAME REBECCA GROVE														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. UNKNOWN					17. INFORMANT JAMES FISLER, 50 CONNER AVE.					18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic										INTERVAL BETWEEN ONSET AND DEATH many years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5/8, 1965 , to Feb 9, 1966 , that (I) (we) last saw the deceased alive on Jan 12, 1966 , and that death occurred at 11 M, from the causes and on the date stated above.																			
22a. SIGNATURE Edson B. Moody					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 2/6/1966									
22c. PHYSICIAN'S NAME (Type) EDSON B. MOODY M.D.					22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN														
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL					23b. DATE THEREOF FEB. 4, 1966					23c. NAME OF CEMETERY OR CREMATORY NORLAND CEMETERY					23d. LOCATION (City, town or county) (State) CHAMBERSBURG PENNA.				
24. FUNERAL DIRECTOR Charles S. Kauter					ADDRESS HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR FEB 11 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Item 18 Film G374 2/20/66</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>02913</div> <div>CERTIFICATE OF DEATH</div> <div>12892</div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>						c. LENGTH OF STAY IN 1b <u>Life</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>						d. STREET ADDRESS <u>132 N. Locust St.</u>					
3. NAME OF DECEASED (Type or print) <u>Flossie L. Flory</u>						4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex. McKalvey</u>						14. MOTHER'S MAIDEN NAME <u>Mary Singer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Pauline Wiederhold</u>		Address <u>Williamsport, Md. 18 N. Potomac St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>nephritis & nephrosclerosis</u> 600.0 DUE TO <u>infectious</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>syphilis</u> DUE TO <u>arteriosclerosis</u> (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arteriosclerosis C.V.D. & gen. arteriosclerosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H.N. Weeks</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>H.N. Weeks M.D.</u>						22d. ADDRESS <u>580 Northern Ave. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>						ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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FOR STATE
HEALTH DEPT. **(M)**

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02893

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b. --- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 230 SUMMIT AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle MARSHALL Last FORD		4. DATE OF DEATH Month FEBRUARY Day 18 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 7, 1894 9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY PAINTING CONTRACT.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM M. FORD	
14. MOTHER'S MAIDEN NAME LAURA BERRY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 218-24-1770		17. INFORMANT HAGERSTOWN, MARYLAND Mrs. JOSEPH M. FORD - 230 SUMMIT AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Phlebitis of the leg DUE TO (c) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Sudden Sev. mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Howard N. Weeks		M.D. HOWARD N. WEEKS, M.D.	
EXAMINER'S NAME (Type) HOWARD N. WEEKS, M.D.		22. DATE SIGNED 2-19-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 22, 1966	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER - HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR FEB 24 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WASHINGTON

330 STREET AVENUE

FEBRUARY 1938

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WASHINGTON

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JANUARY 7, 1938

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WASHINGTON

PAINTING CONTRACT

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330 STREET AVENUE - 330 STREET AVENUE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02913 CERTIFICATE OF DEATH 02894

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 1 YR 2MO. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 407 SHERWOOD DRIVE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 407 SHERWOOD DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADAH Middle RACHAEL Last FRICK		4. DATE OF DEATH Month FEBRUARY Day 12 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1877
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR: Months 00 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY J. DINTINGER		14. MOTHER'S MAIDEN NAME ELIZABETH WASHBURNE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. ROBERT C. FRICK		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 4200 DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1951 , to Feb 12, 1966 , that (I) (we) last saw the deceased alive on Feb 12, 1966 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE L. L. Parker Jr		22b. DATE SIGNED 2/14/66	
22c. PHYSICIAN'S NAME (Type) L. L.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/15/66	23c. NAME OF CEMETERY OR CREMATORY DENISON CEM.	23d. LOCATION (City, town or county) (State) FORTY FORT PENNA.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 17 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02916		02895									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>						d. STREET ADDRESS <u>411 Elizabeth Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Violet Belle Hammer</u>			First Middle Last			4. DATE OF DEATH <u>FEB. 6, 1966</u>			Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bald Eagle, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin McClain</u>						14. MOTHER'S MAIDEN NAME <u>Ella A. Dunlap</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-3835</u>		17. INFORMANT <u>Mr. R.W. Hammer</u> Address <u>411 Elizabeth Ave. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 4, 1963</u> to <u>FEB. 6, 1966</u> , that (I) (two) last saw the deceased alive on <u>FEB. 6, 1966</u> , and that death occurred at <u>6:53 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Efrén Ramirez</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>EFRÉN RAMÍREZ</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hart</u>						ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Feb 4

Hammer

Violet Bell

Sup. 1st 2

CENTRALIZED AUTOMATED
LOCAL PHONIC

11/2/64

Feb 4 1964

Supervisor, 2nd District
FBI, New York

John A. [Signature]
FBI, New York

W. C. [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02917 CERTIFICATE OF DEATH 02896

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waynesboro 75-3	
c. LENGTH OF STAY IN 1b 2 Weeks		d. STREET ADDRESS 715 Fairview Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES G. HARPER		4. DATE OF DEATH Month Day Year Feb. 2 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1885
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR OF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Landis Mach. Co.		10b. KIND OF BUSINESS OR INDUSTRY Machine Tool	
11. BIRTHPLACE (County & State, or foreign country) Bangor Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Harper		14. MOTHER'S MAIDEN NAME Carrie Wamsher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-1188	
17. INFORMANT Mrs. Arch Thomas, 415 W. Sixth St., Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARDIO-PULMONARY COLLAPSE DUE TO (b) CANCER of Right Lung DUE TO (c) PULMONARY EMPHYSEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ANTERIOSEPTEIC HEART DISEASE, ANEMIA INTERVAL BETWEEN ONSET AND DEATH 2 days UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 1966, to 2-2, 1966, that (I) (we) last saw the deceased alive on 2-2, 1966, and that death occurred at 4:50 PM, from the causes and on the date stated above.			
22a. SIGNATURE E. R. Rardizabal		22b. DATE SIGNED 2-3-66	
22c. PHYSICIAN'S NAME (Type) E. R. RARDIZABAL M.D.		22d. ADDRESS 2 North Ave, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/66	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City/town or county) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR Walter G. Greer		25a. REC'D BY REGISTRAR FEB 8 1966	
ADDRESS Waynesboro Pa.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE
FROM: [illegible]
SUBJECT: [illegible]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02918 CERTIFICATE OF DEATH 02897

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 30 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 724 POTOMAC AVENUE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 724 POTOMAC AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARA ELIZABETH HARTLE		4. DATE OF DEATH Month FEBRUARY Day 20 Year 1966					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27, 1896	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAND SEWER		10b. KIND OF BUSINESS OR INDUSTRY DRESS MFG.		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN L. DUTROW					
14. MOTHER'S MAIDEN NAME MARY E. BUSSARD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					
16. SOCIAL SECURITY NO. 217-28-1188		17. INFORMANT JOHN A. HARTLE 633 S. POTOMAC ST.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 1 hr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1950 to 20 Feb, 1966 , that (I) last saw the deceased alive on 15 Feb 1966 , and that death occurred at 11:30 AM from the causes and on the date stated above.					
22a. SIGNATURE J.D. Wilson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/22/1966			
22c. PHYSICIAN'S NAME (Type) J.D. WILSON M.D.		22d. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEBRUARY 23, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			
23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND		24. FUNERAL DIRECTOR Charles J. Jones ADDRESS HAGERSTOWN, MARYLAND					
25a. REC'D BY REGISTRAR FEB 24 1966		25b. REGISTRAR'S SIGNATURE Charles J. Jones					

6811-BS-918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution/Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 1/2 hr</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown 21-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON County.</u>				d. STREET ADDRESS <u>229 S. Prospect St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>TWIN II PAUL</u> First Middle Last				4. DATE OF DEATH <u>Feb 19 1966</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18, 1966</u>		9. AGE (In years last birthday) <u>—</u> yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>10</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD A. HAUVER JR</u>				14. MOTHER'S MAIDEN NAME <u>KITTY-TSCHIFFELY</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Richard A. Hauver, Jr. Thurmont t. MD</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 1 lb 13 oz (Twin)</u> DUE TO (b) <u>Primary incomplete expansion of the lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Twin Premature labor</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/18/</u> , 19 <u>66</u> , to <u>2/19, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/18 1966</u> , and that death occurred at <u>1:34 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A. M. Bacon Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2/20/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. Bacon Jr.</u>				22d. ADDRESS <u>101 King St Hagerstown Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 21. 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cem.</u>		23d. LOCATION (City, town or county) <u>Foxville</u>		(State) <u>Frank Co. Md</u>			
24. FUNERAL DIRECTOR <u>Raymond E. Brager</u>				ADDRESS <u>Thurmont, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

B.P.

76-162426

Presented by Mr. J. C. [unclear]

Three months later

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>8 1/2 hr.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON County</u>				d. STREET ADDRESS <u>229 S. Prospect</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>TWINE PETER</u> First Middle Last				4. DATE OF DEATH <u>Feb</u> <u>19</u> <u>1966</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18, 1966</u>		9. AGE (In years last birthday) <u>8</u> <u>30</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD A. HAUSER JR</u>						14. MOTHER'S MAIDEN NAME <u>KITTY TSCHIFFELY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Richard A Hauser</u> Address <u>Thurmont Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 2 lbs 3 oz (Twin)</u> 7625 DUE TO (b) <u>Prenatal incomplete expansion of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>(Severe)</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Twin - Premature labor</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>66</u> , to <u>2/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>66</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>A.M. Bacon Jr.</u>				22b. DATE SIGNED <u>2/20/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>A.M. Bacon Jr.</u>				22d. ADDRESS <u>101 King St Hagerstown Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt morial cem</u>		23d. LOCATION (City, town or county) (State) <u>Fortville Fred Co Md</u>			
24. FUNERAL DIRECTOR <u>Raymond E. Coeager</u>				ADDRESS <u>Thurmont Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 23 1966</u>											

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. Some fragments are visible, such as "The...", "of...", and "the..."]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>442 W. Church St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Hecker, Jr.</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 19, 1958</u>
9. AGE (in years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles William Hecker, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Lee Straubs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles W. Hecker Sr.</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> <u>8/20</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Crushed Chest</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was struck by a large truck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-33</u> Hour <u>2-3</u> p.m. <u>1966</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown, Washington, Md.</u>		20f. <u>Alley North of W. Franklin St.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>Feb. 4, 1966</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. A. Hunt</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		DATE <u>FEB 8 1966</u>	

023000

MEMORANDUM FOR THE DIRECTOR, FBI

Wm. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02922

02901

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>27 N. Foundry Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>May</u> Last <u>Henson</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11 1901</u> <u>65</u> yrs.	
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>9</u> Hours <u>1</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Maid</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>		13. FATHER'S NAME <u>Alex Bradley Nave</u>	
14. MOTHER'S MAIDEN NAME <u>Ella May Teach</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216 22 7516</u>				17. INFORMANT <u>Mr. Richard Henson</u> Address <u>27 N. Foundry Street Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Respiratory Disturbance</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1966</u> to <u>Feb 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 22, 1966</u> and that death occurred at <u>4:40</u> M, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <u>J.H. Beachley</u>				22b. DATE SIGNED <u>2/23/66</u>		22c. PHYSICIAN'S NAME (Type) <u>J.H. Beachley</u>	
22d. ADDRESS <u>Hagerstown Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>				25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14050

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02923 CERTIFICATE OF DEATH 02902

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 343 Central Ave	
3. NAME OF DECEASED (Type or print) Early Russell Hicks		4. DATE OF DEATH Feb. 27, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Hicksville Md		12. COUNTRY OF WHAT CITIZEN? U.S.A.	
13. FATHER'S NAME Rev. Cadmus M. Hicks		14. MOTHER'S MAIDEN NAME Mary Dennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 219-36-3833	
17. INFORMANT Mrs Agnes Gearhart		Address 343 Central Ave Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO (b) Diabetic Glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity - Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March, 1946 to Feb 27, 1966 , that (I) (we) last saw the deceased alive on 2-27-66 , and that death occurred at 6:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE John C. Morton, M.D.		22b. DATE SIGNED 3-2-66	
22c. PHYSICIAN'S NAME (Type) John C. Morton, M.D.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 2, 1966	
23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		23d. LOCATION (City, town or county) (State) Broadfording, Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Funeral Home Inc. 10 East Antietam St. Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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John D. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>2</div> <div>1</div> <div>02924</div> <div>02904</div>											
1. PLACE OF DEATH e. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Md.						c. LENGTH OF STAY IN 1b 30yrs					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS 317¹/₂ N Jonathan Street					
3. NAME OF DECEASED (Type or print) Frances						4. DATE OF DEATH Month Feb Day 4 Year 1966					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 12 1913		9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months 4 Days 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (County & State, or foreign country) Keedysville, Md.				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Roy Keats						14. MOTHER'S MAIDEN NAME Lottie E. Keats					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 214-16-0867		17. INFORMANT Address Mrs. Edward Brown 308 N. Jonathan St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 1992 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Origin undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 Mo											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 65 2/4		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/9 to 2/4 , 19 65 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 2/4 , 19 65 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Donald E. Martin						ATTENDING PHYS. <input type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> 2/12/66	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin M.D.						22d. ADDRESS 418 North Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-8-1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.						ADDRESS		25a. REC'D BY REGISTRAR FEB 9 1966		25b. REGISTRAR'S SIGNATURE John R. Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02925		02905	
1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1200 Rose Hill Ave		d. STREET ADDRESS 1200 Rose Hill Ave	
3. NAME OF DECEASED (Type or print) First Middle Last LUTHER ISAAC KIEFER		4. DATE OF DEATH Month Day Year Feb 5 1966 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Dec 25 1882
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Mercersburg Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Keefer		14. MOTHER'S MAIDEN NAME Mary Hornbaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs Emma M. Keefer		Address 1200 Rose Hill Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis, Severe With Intramural 4201 DUE TO Hemorrhage Anterior Descending (b) Chronic Pyelonephritis (c) Hydronephrosis, Bilateral (c) Cardiac Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. DATE SIGNED 2-7-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-9-66	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (city, town or county) (State) Hagerstown Wash. Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR FEB 14 1966	
Hagerstown Md ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. F. D. # 1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown 21-1	
f. STREET ADDRESS R. F. D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NAOMIA ELIZABETH KLINE		4. DATE OF DEATH February 5 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1901
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Wolfsville, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Will Williams		14. MOTHER'S MAIDEN NAME Anna Witmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-24-5814	
17. INFORMANT J. Russell Kline Hag. Md. Rt. 1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio vascular Failure DUE TO (b) Myocardial Disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 4222
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/4/66 , 19 66 , to 2/5/66 , that (I) (we) last saw the deceased alive on 2/4/66 , 19 66 , and that death occurred at 2/5/66 M, from causes and on the date stated above.			
22a. SIGNATURE Louis G. Graft		22b. DATE SIGNED 2/5/66	
22c. PHYSICIAN'S NAME (Type) Louis G. Graft		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-8-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	23d. LOCATION (City or Town) (County) (State) Near Smithsburg, Md.
24. FUNERAL DIRECTOR Scott F. Minnich & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 10 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02927		02907	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	
c. LENGTH OF STAY in lb 36 Yrs.		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 105 St. Paul St.		d. STREET ADDRESS 105 St. Paul St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Winton Middle Ernest Last Knode		4. DATE OF DEATH Month February Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1906
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months 10 Days 27 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Shoe Manufacturing	
11. BIRTHPLACE (County & State, or foreign country) Rohrersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard Knode		14. MOTHER'S MAIDEN NAME Alta Haller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-09-5713HA	
17. INFORMANT Mrs. Ellen Knode, Boonsboro, Md.		105 St. Paul St. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bone 1969 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 5, 1965 to Feb 23, 1966 , that (I) (we) last saw the deceased alive on Feb 23, 1966 , and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>G. W. HeVan</i>		22b. DATE SIGNED March 2, 1966	
22c. PHYSICIAN'S NAME (Type) G. W. HeVan		22d. ADDRESS Boonsboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3- 3- 66	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main S., Boonsboro, Md.		25a. REC'D BY REGISTRAR MAR 4 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE PENNA. b. COUNTY FRANKLIN					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN						c. LENGTH OF STAY IN lb 18 HRS.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL						d. STREET ADDRESS 502 EAST BALTIMORE ST.					
3. NAME OF DECEASED (Type or print) HARRY C. KRINER						4. DATE OF DEATH FEBRUARY 4, 1966					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1881		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FRUIT GROWER, DEALER						10b. KIND OF BUSINESS OR INDUSTRY ORCHARD, LIVESTOCK		11. BIRTHPLACE (County & State, or foreign country) FRANKLIN CO. PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONAS KRINER						14. MOTHER'S MAIDEN NAME EMMA ELLIOTT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 198-30-4387		17. INFORMANT Ray R. Kriner, Dayton, New Jersey			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIO-SCLEROSIS (GENERALIZED) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 16 HRS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 1964 to Feb. 1966 , that (I) (we) last saw the deceased alive on 3 FEB 1966 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE P F WEBSTER M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 Feb 66			
22c. PHYSICIAN'S NAME (Type) P F WEBSTER						22d. ADDRESS GREENCASTLE, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/6/1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Greencastle, Franklin Co. Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE Donald M. Zimmerman ADDRESS Green castle, Pa						25a. REC'D BY REGISTRAR FEB 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 30 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1700 GORDON RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARIE Middle JOYCE Last LEHMAN			4. DATE OF DEATH Month FEBRUARY Day 21 Year 19 66						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/21/1908		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MICHIGAN			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK C. KAETZEL					14. MOTHER'S MAIDEN NAME BESSIE WELLS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-09-0789		17. INFORMANT MR. RICHARD H. LEHMAN			Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, Massive 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Cholecystitis with Cholelithiasis (operated 2/5/66)								INTERVAL BETWEEN ONSET AND DEATH 7 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-31- , 19 48 , to 2-21 , 19 66 , that (I) (we) last saw the deceased alive on 2-21- 19 66 , and that death occurred at 10 P. M. from the causes and on the date stated above.									
22a. SIGNATURE Dalton M. Welty					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/66		
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty					22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/24/66		23c. NAME OF CEMETERY OR CREMATORY CHURCH OF BRETHREN			23d. LOCATION (City, town or county) (State) BROWNSVILLE MD.		
24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md.					25a. REC'D BY REGISTRAR FEB 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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REAGENTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		d. STREET ADDRESS 5113 Brinkley Road	
3. NAME OF DECEASED (Type or print) Thomas A. Lloyd		4. DATE OF DEATH Feb. 23 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (in years last birthday) 84 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		9b. KIND OF BUSINESS OR INDUSTRY	
10. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Thomas A. Lloyd		13. MOTHER'S MAIDEN NAME Mary E. Lennett	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		15. SOCIAL SECURITY NO. 578 12 5190	
16. INFORMANT Mrs Wilbur Maines		Address Same as # 2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE PROSTATE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DEHYDRATION AND MALNUTRITION		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-18, 1966 , to 2-23, 1966 , that (I) (we) last saw the deceased alive on 2-23 - 1966 , and that death occurred at 12:4 M , from the causes and on the date stated above.			
22a. SIGNATURE Efren A. Ramirez		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EFREN A. RAMIREZ		22d. ADDRESS 1500 PENN. AVE, HAGERSTOWN MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/26/1966	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Suitland, Md	
24. FUNERAL DIRECTOR Matthew 131-1117 S.E. D.C.		25a. REC'D BY REGISTRAR FEB 25 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1020

1

State of Maryland
County of Prince George's
I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court.

Witness my hand and the seal of the Court at Prince George's County, Maryland, this 1st day of June, 1901.

John A. Bannister, Clerk of the Court.

1901
June 1st
John A. Bannister, Clerk of the Court.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Burkittsville, 10-2		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Armstead		First U.		Middle Magaha		Last Magaha		4. DATE OF DEATH Feb. 3 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 5, 1873		9. AGE (in years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin Magaha		14. MOTHER'S MAIDEN NAME Julia Bond		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-36-0409		17. INFORMANT Louise Magaha		Address Burkittsville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Emaciation</i> DUE TO (c) <i>Adenocarcinoma prostate with metastases</i>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		22a. SIGNATURE <i>John J. Drury</i>		22b. DATE SIGNED 2-4-66		22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town or county) (State) Burkittsville, Md.		24. FUNERAL DIRECTOR Gladhill Co.		25a. REC'D BY REGISTRAR FEB 8 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS Middletown, Md.	

42014

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

REPORT OF THE
COMMISSIONER OF PLANT INDUSTRY
FOR THE YEAR 1914
CONTAINING
A SUMMARY OF THE WORK OF THE BUREAU
AND A LIST OF THE PLANTS INTRODUCED
DURING THE YEAR

THE BUREAU OF PLANT INDUSTRY
WAS ORGANIZED IN 1902
AS A DIVISION OF THE
BUREAU OF AGRICULTURE
AND WAS REORGANIZED
IN 1914 AS A
SEPARATE BUREAU
UNDER THE DEPARTMENT OF AGRICULTURE
THE BUREAU HAS THE HONOR
TO ANNOUNCE THAT
IT HAS RECEIVED
FROM THE
GOVERNMENT OF THE
UNITED STATES
A GRANT OF
\$10,000
FOR THE
PURCHASE OF
PLANTS
AND
MATERIALS
FOR THE
CULTIVATION
OF
PLANTS
AND
THE
PREPARATION
OF
PLANT
SPECIMENS
FOR
THE
HERBARIUM
OF
THE
BUREAU
OF
PLANT
INDUSTRY
THE
GRANT
WAS
MADE
AVAILABLE
ON
JANUARY
1, 1915
AND
THE
BUREAU
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02932 CERTIFICATE OF DEATH 02912

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN lb 14 Yrs 3 Mos		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Penna		b. COUNTY York		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover		d. STREET ADDRESS 217 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA SHUE MAJOR		4. DATE OF DEATH Feb 3 1966		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 10 1880		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Glenville York Co Pa.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Zacharias Shue		14. MOTHER'S MAIDEN NAME Emaline Tracey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mark G. Wagner		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1965 , to Feb 3, 1966 , that (I) (we) last saw the deceased alive on Feb 1, 1966 , and that death occurred at 8:50 A.M. , from the causes and on the date stated above.		22a. SIGNATURE Robert P. Conrad		22b. DATE SIGNED 2-4-66		22c. PHYSICIAN'S NAME (Type) Robert P. Conrad		22d. ADDRESS 137 W. Washington Hagerstown, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Feb 7 1966		23c. NAME OF CEMETERY OR CREMATORY St Jacobs Stone Ch Cem		23d. LOCATION (City, town or county) (State) York Broadbeck Co Pa		24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR FEB 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. NAME OF CEMETERY OR CREMATORY St Jacobs Stone Ch Cem		25d. LOCATION (City, town or county) (State) York Broadbeck Co Pa	

MEDICAL CERTIFICATION

Journal of Management Education 30(6)

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02933									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1 yr. 2 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Waynesboro</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> d. STREET ADDRESS <u>84 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ANNA C</u>			4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Greencastle, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cantner</u>					14. MOTHER'S MAIDEN NAME <u>Sally Foreman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>265-600524</u>		17. INFORMANT <u>Mrs. Elsie Boykin</u>		Address <u>Waynesboro, Pa.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>Febr 11</u> , 19 <u>66</u> , to <u>Febr 13</u> , 19 <u>66</u> that (2) (we) last saw the deceased alive on <u>Febr 11</u> , 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M.E. Byrkit</u>					22b. DATE SIGNED <u>2-13-66</u>		22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		
22d. ADDRESS <u>Williamsport Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town or county) (State) <u>Waynesboro Franklin Co, Pa</u>		
24. FUNERAL DIRECTOR <u>Walter J. Grove, Waynesboro Pa</u>					25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MARYLAND STATE HOSP.</u>		d. STREET ADDRESS <u>5406 NASH STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Otelia</u> Middle <u>G.</u> Last <u>McCollough</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negress</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/27</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses H.D. Hospital</u>		9b. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses H.D. Hospital</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WEST VIRGINIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES G. FERGUSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH L. PIERCE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>232-38-0458</u>	
17. INFORMANT <u>William McCollough</u>		Address <u>5406 NASH ST. Chapel Oaks</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1973</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fibrosarcoma, Left Leg</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u> <u>10 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>66</u> , to <u>2/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Riego</u>		22b. DATE SIGNED <u>2/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR RIEGO</u>		22d. ADDRESS <u>1500 Penna. Avenue Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John T. Stewart Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Stewart Funeral Home 4001 Benning Rd.,</u>		25c. DATE <u>FEB 24 1966</u>	

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[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "REPORT" and "DATE" are visible.]

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VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02935		02915									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 9 MRS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				d. STREET ADDRESS 1324 HAMILTON BLVD.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) PAUL DONALDSON McCOY			First Middle Last			4. DATE OF DEATH Month FEBRUARY Day 16 Year 1966			5. SEX MALE		
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/1923		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min.		IF UNDER 24 HRS. Months 1 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR OF DENTISTRY				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL McCOY						14. MOTHER'S MAIDEN NAME NELLIE HANNA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.#2		17. INFORMANT MRS. JOANNE McCOY MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO (b) Coronary insuff. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic cardiac dis.		INTERVAL BETWEEN ONSET AND DEATH 1 day 3-4 yrs 4 + yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Oct , 19 57 , to 16 Feb , 19 66 , that (I) (we) last saw the deceased alive on 16 Feb , 19 66 , and that death occurred at 8 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE Richard T. Binford NAME (Type) RICHARD T. BINFORD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 Feb 66		22c. ADDRESS HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/19/66		23c. NAME OF CEMETERY OR CREMATORY PHILOS CEM.				23d. LOCATION (City, town or county) (State) WESTERNPORT MD.			
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR FEB 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

WASHINGTON

WASHINGTON

D. MRS.

WASHINGTON

WASHINGTON COUNTY HOSPITAL

1324 HAMILTON BLVD.

FEBRUARY 18 1960

DANIEL DONALDSON 1000

WASHINGTON

WASHINGTON

DOCTOR OF DENTISTRY

PAUL HOGG

WASHINGTON

MRS. KATHLEEN HOGG

WASHINGTON

*See Washington
County Hospital
Washington*

Richard A. Hogg

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02936 CERTIFICATE OF DEATH 02916											
1. PLACE OF DEATH a. COUNTY <i>Washington Co.</i> <i>Item 9 Fall 6374 2/28/66</i> <i>Hagerstown - Md -</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						d. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Maryland State Hospital - Hagerstown Md</i>						d. STREET ADDRESS <i>815-62nd Pl. Cedar N.E.</i>					
3. NAME OF DECEASED (Type or print) <i>Thelma Alberta Nelson</i>						4. DATE OF DEATH Month <i>Feb.</i> Day <i>19</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>NEGRESS</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/18/24</i>		9. AGE (In years last birthday) <i>42</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>19</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horse wife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas Mitchell</i>						14. MOTHER'S MAIDEN NAME <i>Emma Ellis</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Delores Nelson Boomer</i> Address <i>(Daughter)</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular Pneumonia</i> <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Hemorrhage</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>11-2, 1965</i> to <i>2-19, 1966</i> , that (I) (we) last saw the deceased alive on <i>2-19 - 1966</i> , and that death occurred at <i>2:18 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Arthur Riego</i>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>2/19/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>ARTHUR RIEGO</i>						22d. ADDRESS <i>1500 Penna. Ave. Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>2-23-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Lanham P.G.Co. Md</i>			
24. FUNERAL DIRECTOR <i>William Spangler - 524-8-St NE - Wash. D.C.</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>FEB 23 1966</i>											

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		21. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Route #3- Bedford Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pleasant M. Messick		4. DATE OF DEATH Feb. 21 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania (Bedford) Co		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Hardman		14. MOTHER'S MAIDEN NAME Alice Mann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 177-32-9952	
17. INFORMANT Mrs. Aubrey A. Chambers		Address Route #3 Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Lobular Pneumonia DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 10 days 8 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13, 1965, to 2/24, 1966, that (I) (we) last saw the deceased alive on 2/21, 1966, and that death occurred at 10:30 M, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Arthur R. Ego		22d. ADDRESS 1501 Penna. Ave. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/66	
23c. NAME OF CEMETERY OR CREMATORY Mt Herman Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox		25a. REC'D BY REGISTRAR FEB 24 1966	
Cumberland Maryland 21502		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 9 mos.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont 10-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maude Catherine Messner			First Middle Last		4. DATE OF DEATH Feb. 1, 1966		Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1893		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Isanogle					14. MOTHER'S MAIDEN NAME Emma Eicholtz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-03-3923		17. INFORMANT Grace Baker 249 Fred. St. Hagerstown					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) unknown								INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus (2) old posterior myocardial infarction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 7, 1965 , to Feb. 1, 1966 , that (I) (we) last saw the deceased alive on Feb. 1, 1966 , and that death occurred at 1:40 PM , from the causes and on the date stated above.										
22a. SIGNATURE Victor L. Ramos					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 4, 1966			
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS					22d. ADDRESS Western Md. State Hospital Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-66		23c. NAME OF CEMETERY OR CREMATORY United Brethren Cem.		23d. LOCATION (City, town or county) (State) Thurmont Fred. Co. Md				
24. FUNERAL DIRECTOR Raymond C. Beager					ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR FEB 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

USA

1953

Washington, D.C.
January 1, 1953

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation
Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

recent visit of the Soviet Ambassador to the United States.

I have been informed that the Ambassador's visit was

quite successful and that the Ambassador was well received.

I am sure that the visit was a most profitable one for both sides.

I am sure that the Ambassador's visit was a most profitable one for both sides.

I am sure that the Ambassador's visit was a most profitable one for both sides.

I am sure that the Ambassador's visit was a most profitable one for both sides.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02939

CERTIFICATE OF DEATH

02919

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Samuel Last Naille		4. DATE OF DEATH Month February Day 4 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1890
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 8 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) Rural Myersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David H. Naille		14. MOTHER'S MAIDEN NAME Missouri Harshman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-12-1879	
17. INFORMANT Mr. Elvin Naille, Myersville Rfd. 1 Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis - Hypertensive C-V Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1965 , to 4 Feb. 1966 , that (I) (we) last saw the deceased alive on 3 Feb. 1966 , and that death occurred at 1:15 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 5 Feb 66	
22c. PHYSICIAN'S NAME (Type) W. H. FENNER		22d. ADDRESS 218 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-7-66	
23c. NAME OF CEMETERY OR CREMATORY Cemetery		23d. LOCATION (City or Town) (County) (State) Myersville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR FEB 8 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

01050

REPORT TO DIRECTOR

100-100000

TO : DIRECTOR, FBI (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

REFERENCE: [Illegible]

COMMENTS: [Illegible]

ADMINISTRATIVE: [Illegible]

APPROVAL: [Illegible]

DISTRIBUTION: [Illegible]

ENCLOSURES: [Illegible]

COPIES: [Illegible]

REMARKS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport 2</u> c. LENGTH OF STAY IN ID <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Canal Road</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RD 2</u> d. STREET ADDRESS <u>Canal Road 21-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Waters</u> Last <u>Ohler</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Craft</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alfius Clem Charles</u>		14. MOTHER'S MAIDEN NAME <u>Katorah Susan Harbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War #1</u>		16. SOCIAL SECURITY NO. <u>216-09-7853</u>	
17. INFORMANT <u>Mr. Glenn V. Ohler</u>		Address <u>Takoma Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of Transverse Colon With Erosion</u> 1531 DUE TO <u>Into Stomach, Obstruction, & Massive</u> (b) <u>Hemorrhage.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>3-2-66</u>	
Address (Street, city, town, or county) <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 4 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05050

6525

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02921

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN ID D.O A	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 34 Walnut St.	
3. NAME OF DECEASED (Type or print) William Luther Palmer		4. DATE OF DEATH Month February Day 11 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1910
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fairchild	
11. BIRTHPLACE (State or foreign country) Cearfoss, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David L. Palmer		14. MOTHER'S MAIDEN NAME Miley Cunningham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W #2		16. SOCIAL SECURITY NO. 219-05-2327	
17. INFORMANT Donald L. Palmer		Address 215 James St Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Of Gastric Fluid, Marked 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis, Moderately Severe Several years DUE TO Coronary Thromboses (Probable) Branch Of Left Several years (c) Circumflex Major Twig Of Left Anterior Descending.			INTERVAL BETWEEN ONSET AND DEATH Few minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 2-12-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 13, 1966	23c. NAME OF CEMETERY OR CREMATORY Church Of Brethern	23d. LOCATION (City, town or county) (State) Near Hagerstown, Md
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Md		25a. REC'D BY REGISTRAR FEB 15 1966 DATE	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0504

Corporation of the State of New York
Incorporated under the laws of the State of New York
Capital Stock \$1,000,000.00
Paid-up Capital \$1,000,000.00
Surplus \$1,000,000.00
Total \$3,000,000.00

[Handwritten signature]

5-10-44
Incorporated in
the State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.					c. LENGTH OF STAY IN lb 5yrs.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland				
					d. STREET ADDRESS 138 W. North Street				
3. NAME OF DECEASED (Type or print) Eugene (none) Parker					4. DATE OF DEATH Month Feb Day 28 Year 1966				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 9 1912		9. AGE (In years last birthday) 53 yrs.	
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Packing house				11. BIRTHPLACE (County & State, or foreign country) Middlestown, Va.	
								12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Elias Parker					14. MOTHER'S MAIDEN NAME Emma Anker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 230-09-7094		17. INFORMANT Charlotte Parker 138 W. North St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 66 to 2/28 , 19 66 , that (I) (we) last saw the deceased alive on 2/28 , 19 66 , and that death occurred at 10:50 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Do-nald E. Martin					M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/28/66
22c. PHYSICIAN'S NAME (Type) Do-nald E. Martin M.D.					22d. ADDRESS 418 North Potomac St. Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-8-1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.		
24 FUNERAL DIRECTOR'S SIGNATURE John K Watson of Hagerstown Md.					ADDRESS		25a. REC'D BY REGISTRAR MAR 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02943

02924

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rohrsersville c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rohrsersville Rfd. 1 21-1 d. STREET ADDRESS Locust Grove e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nyle Middle C. Last Poffenberger		4. DATE OF DEATH Month February Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1910
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (County & State, or foreign country) Locust Grove, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harmon Poffenberger		14. MOTHER'S MAIDEN NAME Mary S. Poffenberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-09-9102	
17. INFORMANT Mrs. Dorothy M. Poffenberger,		Address Rohrsersville Rfd. 1, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 hour 47 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-18- , 19 61 , to 2-13 , 19 66 , that (I) (we) last saw the deceased alive on 2-13- 19 66 , and that death occurred at 17:00 M, from causes and on the date stated above.			
22a. SIGNATURE J. Secodari		22b. DATE SIGNED 2-14-66	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDA RI		22d. ADDRESS Boonsboro Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-15-66	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR FEB 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside d. STREET ADDRESS 4803 M street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Inez Middle Mary Last Pride					4. DATE OF DEATH Month Feb. Day 7, Year 19 66				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 7, 1915		9. AGE (In years last birthday) 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 578 26 1978		17. INFORMANT Address Earl C Pride Hillside Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 157X DUE TO (b) GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) BETROPERITONEAL CARCINOMA									INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JAN. 13, 1966 , to FEB. 7, 1966 , that (I) (we) last saw the deceased alive on FEB. 7, 1966 , and that death occurred at 2:58 M. from the causes and on the date stated above.									
22a. SIGNATURE Antonio H. Pallagrosi					ATTENDING PHYS. <input type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-7-66
22c. PHYSICIAN'S NAME (Type) ANTONIO Pallagrosi					22d. ADDRESS Western Md. State Hospital Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb 10, 1966		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington D. C.		
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR 55B 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

02087

OFFICE OF DEATH

Washington

For Mary Price
Feb 11 1912

GENERALIZED CARIES
RETENTION OF CARIES

Jan 13 1912

Dr. J. H. Smith

Patent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02945 CERTIFICATE OF DEATH 02926											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield 21-1				d. STREET ADDRESS Box 45	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence W. Pryor Sr.			First Middle Last			4. DATE OF DEATH Feb. 24 1966			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1897		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Military Reservation		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Pryor						14. MOTHER'S MAIDEN NAME Amanda Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 219-12-0773		17. INFORMANT Mrs. Anna Prichard		Address Highfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1-29-1966, to 2-24-1966, that (I) (we) last saw the deceased alive on 2-24-1966, and that death occurred at 11A M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Dalton M. Welty</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 2-24-66		
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY						22d. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/27/66		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City, town or county) (State) Lantz, Frederick Co., Md.			
24. FUNERAL DIRECTOR <i>Valley of Grace</i>						25a. REC'D BY REGISTRAR Waynesboro, Penna.		25b. REGISTRAR'S SIGNATURE MAR 1 1966 <i>J. Charles Judge</i>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

02946
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
02927

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SHARPSBURG c. LENGTH OF STAY IN ID 82 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D.# 3 SHARPSBURG		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SHARPSBURG d. STREET ADDRESS R.D.#. 3 SHARPSBURG e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY MARIE REEL First Middle Last		4. DATE OF DEATH FEBRUARY 26 19 66 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS REEL		14. MOTHER'S MAIDEN NAME MARY GRICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-38-0787	
17. INFORMANT SHERIDAN REEL		Address R.D.# 3 SHARPSBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH Instant Recent	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto EXAMINER'S NAME (Type) EDWARD W. DITTO		M.D. MR. M.D. 215 W. WASHINGTON ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 1, 1966	
23c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, MARYLAND	
24. FUNERAL DIRECTOR Charles R. Rouse ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 4 1966 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED

DEALERS REPORT

U.S. SHARPS

RECEIVED

U.S. SHARPS

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U.S. SHARPS

10-10-00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02947					02928				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN ID <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>53 Elizabeth St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gregory</u> First <u>Lynn</u> Middle <u>Resseger</u> Last			4. DATE OF DEATH <u>Feb.</u> Month <u>1</u> Day <u>19</u> Year <u>66</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27 1965</u>		9. AGE (In years last birthday) yrs. <u>11</u> Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Resseger</u>					14. MOTHER'S MAIDEN NAME <u>Dorothy Hetzel</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>53 Elizabeth St. Hagerstown</u> <u>Mrs. Dorothy Resseger Maryland</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>gastro-intestinal</u> DUE TO (c) <u>Dehydration</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> , 19 <u>66</u> , to <u>2-1-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-1-</u> 19 <u>66</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-1-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>					22d. ADDRESS <u>BOONS BORO</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>Feb. 5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Samples Manor Maryland</u>		
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>					25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02929

<p>1. PLACE OF DEATH a. COUNTY Washington MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pleasant Valley Life</p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pleasant Valley 21-1</p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence</p>				<p>d. STREET ADDRESS RFD #2, Knoxville, Md.</p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last GEORGE DEWEY RICKERDS, Sr.</p>				<p>4. DATE OF DEATH Month Day Year February 17, 19 66</p>			
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH May 15, 1899</p>	
<p>9. AGE (In years last birthday) 66 yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>11. BIRTHPLACE (State or foreign country) Garrett's Mill, Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Francis Marion Rickerds</p>				<p>14. MOTHER'S MAIDEN NAME Annie Belle Ohler</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None</p>		<p>17. INFORMANT Mrs. Leoda C. Rickerds RFD #2, Knoxville, Md. 21758</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe coronary artery disease DUE TO (c)</p>							<p>INTERVAL BETWEEN ONSET AND DEATH 2-5 yrs.</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour a. m. p. m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from 1-15-66, to 2-17-66, that I last saw the deceased alive on 2-17-66, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE C. E. Pruitt</p>				<p>ADDRESS (Street, city or town, state) Brunswick, Md.</p>		<p>DATE SIGNED 2-19-66</p>	
<p>PHYSICIAN'S NAME (Type) C. E. Pruitt Brunswick, Maryland</p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 2/20/66</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Brownsville Hts. Cemetery</p>		<p>22d. LOCATION (City, town, or county) (State) Brownsville, Maryland</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE Donald Ackles</p>				<p>ADDRESS Harper's Ferry, W. Va.</p>		<p>24a. REC'D BY REGISTRAR DATE FEB 24 1966</p>	
				<p>24b. REGISTRAR'S SIGNATURE Charles Judge</p>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH</p>		<p>6. OCCUPATION 7. MARITAL STATUS 8. COLOR OF HAIR 9. COLOR OF EYES</p>	
<p>10. DATE OF DEATH 11. TIME OF DEATH 12. PLACE OF DEATH</p>		<p>13. CAUSE OF DEATH 14. MANNER OF DEATH</p>	
<p>15. SIGNATURE OF PHYSICIAN 16. SIGNATURE OF REGISTRAR</p>		<p>17. SIGNATURE OF WITNESSES 18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED 20. SIGNATURE OF WITNESSES</p>		<p>21. SIGNATURE OF DECEASED 22. SIGNATURE OF WITNESSES</p>	
<p>23. SIGNATURE OF DECEASED 24. SIGNATURE OF WITNESSES</p>		<p>25. SIGNATURE OF DECEASED 26. SIGNATURE OF WITNESSES</p>	
<p>27. SIGNATURE OF DECEASED 28. SIGNATURE OF WITNESSES</p>		<p>29. SIGNATURE OF DECEASED 30. SIGNATURE OF WITNESSES</p>	
<p>31. SIGNATURE OF DECEASED 32. SIGNATURE OF WITNESSES</p>		<p>33. SIGNATURE OF DECEASED 34. SIGNATURE OF WITNESSES</p>	
<p>35. SIGNATURE OF DECEASED 36. SIGNATURE OF WITNESSES</p>		<p>37. SIGNATURE OF DECEASED 38. SIGNATURE OF WITNESSES</p>	
<p>39. SIGNATURE OF DECEASED 40. SIGNATURE OF WITNESSES</p>		<p>41. SIGNATURE OF DECEASED 42. SIGNATURE OF WITNESSES</p>	
<p>43. SIGNATURE OF DECEASED 44. SIGNATURE OF WITNESSES</p>		<p>45. SIGNATURE OF DECEASED 46. SIGNATURE OF WITNESSES</p>	
<p>47. SIGNATURE OF DECEASED 48. SIGNATURE OF WITNESSES</p>		<p>49. SIGNATURE OF DECEASED 50. SIGNATURE OF WITNESSES</p>	
<p>51. SIGNATURE OF DECEASED 52. SIGNATURE OF WITNESSES</p>		<p>53. SIGNATURE OF DECEASED 54. SIGNATURE OF WITNESSES</p>	
<p>55. SIGNATURE OF DECEASED 56. SIGNATURE OF WITNESSES</p>		<p>57. SIGNATURE OF DECEASED 58. SIGNATURE OF WITNESSES</p>	
<p>59. SIGNATURE OF DECEASED 60. SIGNATURE OF WITNESSES</p>		<p>61. SIGNATURE OF DECEASED 62. SIGNATURE OF WITNESSES</p>	
<p>63. SIGNATURE OF DECEASED 64. SIGNATURE OF WITNESSES</p>		<p>65. SIGNATURE OF DECEASED 66. SIGNATURE OF WITNESSES</p>	
<p>67. SIGNATURE OF DECEASED 68. SIGNATURE OF WITNESSES</p>		<p>69. SIGNATURE OF DECEASED 70. SIGNATURE OF WITNESSES</p>	
<p>71. SIGNATURE OF DECEASED 72. SIGNATURE OF WITNESSES</p>		<p>73. SIGNATURE OF DECEASED 74. SIGNATURE OF WITNESSES</p>	
<p>75. SIGNATURE OF DECEASED 76. SIGNATURE OF WITNESSES</p>		<p>77. SIGNATURE OF DECEASED 78. SIGNATURE OF WITNESSES</p>	
<p>79. SIGNATURE OF DECEASED 80. SIGNATURE OF WITNESSES</p>		<p>81. SIGNATURE OF DECEASED 82. SIGNATURE OF WITNESSES</p>	
<p>83. SIGNATURE OF DECEASED 84. SIGNATURE OF WITNESSES</p>		<p>85. SIGNATURE OF DECEASED 86. SIGNATURE OF WITNESSES</p>	
<p>87. SIGNATURE OF DECEASED 88. SIGNATURE OF WITNESSES</p>		<p>89. SIGNATURE OF DECEASED 90. SIGNATURE OF WITNESSES</p>	
<p>91. SIGNATURE OF DECEASED 92. SIGNATURE OF WITNESSES</p>		<p>93. SIGNATURE OF DECEASED 94. SIGNATURE OF WITNESSES</p>	
<p>95. SIGNATURE OF DECEASED 96. SIGNATURE OF WITNESSES</p>		<p>97. SIGNATURE OF DECEASED 98. SIGNATURE OF WITNESSES</p>	
<p>99. SIGNATURE OF DECEASED 100. SIGNATURE OF WITNESSES</p>		<p>101. SIGNATURE OF DECEASED 102. SIGNATURE OF WITNESSES</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

RECEIVED
 BALTIMORE, MARYLAND
 JAN 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02949

02930

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN lb 33yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland d. STREET ADDRESS 675 Pennsylvania Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William McKinley Russ			4. DATE OF DEATH Month Feb Day 9 Year 1966		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 8 1902	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Army Depot		11. BIRTHPLACE (County & State, or foreign country) Middleway W. Va.	
13. FATHER'S NAME Warner McKinley			12. CITIZEN OF WHAT COUNTRY? USA.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			16. SOCIAL SECURITY NO. 220-10-3877		
17. INFORMANT William Russ			Address 663 Pennsylvania Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Pulmonary Emboli					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1966	(County) 2-9-	(State) 1966
21. I certify that (I) (this hospital) attended the deceased from 2-7 , 19 66 to 2-9 , 19 66 that (I) (we) last saw the deceased alive on 2-7 , 19 66 , and that death occurred at 5:30 PM , from the causes and on the date stated above.					
22a. SIGNATURE Dalton M. Welty 22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.			22b. DATE SIGNED 2-11-66 22d. ADDRESS 998 Potomac Avenue, Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-12-1966	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) Hagerstown, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md			25a. REC'D BY REGISTRAR FEB 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge		

02030

THE OFFICE OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 HRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 322 N. CANNON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Russell		4. DATE OF DEATH Month February Day 23 Year 1966	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 28, 1908	
9. AGE (In years last birthday) 57 yrs.		10. FINDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY COUNTY COURT HOUSE WASHINGTON CO., MD.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN RUSSELL		14. MOTHER'S MAIDEN NAME MARY ALBERT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-8587	
17. INFORMANT MRS. HELEN RUSSELL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm, abdominal aorta below bifurcation of renal arteries with dissection of the arterial coats Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 451X DUE TO (c) X08670	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and atherosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) was not present attended the deceased from Feb. 23, 1966 to Feb. 23, 1966 , that (I) was last saw the deceased alive on Feb. 23, 1966 , and that death occurred at 11:20 A M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William T. Layman</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg., Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/26/1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON CO., MARYLAND	
24. FUNERAL DIRECTOR <i>Charles R. Judge</i>		25a. REC'D BY REGISTRAR HAGERSTOWN, MARYLAND	
25b. REGISTRAR'S SIGNATURE <i>Charles R. Judge</i>		DATE MAR 1 1966	

1. The first of these is the fact that the majority of the population of the United States is now living in urban areas. This is a result of the process of urbanization, which has been going on since the beginning of the 20th century. The population of the United States has increased from about 100 million in 1900 to over 200 million in 1960. At the same time, the population of rural areas has decreased from about 100 million in 1900 to about 50 million in 1960. This has led to a concentration of the population in urban areas, which has had a profound effect on the economy and society.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02951 CERTIFICATE OF DEATH 02932

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Fredricksburg</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Friendship Manor Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Charles Town</u> <u>85-3</u> d. STREET ADDRESS <u>600 Brook St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>GERARDO PAUL SALSAVO</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 13, 1901</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Cab operator</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Taxi Cab operator</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unk.</u>						14. MOTHER'S MAIDEN NAME <u>Unk.</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>217039514</u>				17. INFORMANT <u>Mrs. Louella Salzano Charles Town</u>				Address <u>W. Va.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>490 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diffuse Bi-Lateral Pneumonia</u> DUE TO (c) <u>Cerebral Syndrome</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 20</u> , 19 <u>66</u> , to <u>Feb 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 27</u> , 19 <u>66</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>J. H. Beasley</u>												22b. DATE SIGNED <u>Feb 27/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>J. H. Beasley</u>												22d. ADDRESS <u>Hagerstown, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/3/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>				23d. LOCATION (City, town or county) (State) <u>Quincy Md</u>							
24. FUNERAL DIRECTOR <u>E. Guy Daves C. Town</u>												25a. REC'D BY REGISTRAR <u>MAR 2 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

43 1091-5-74

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clearspring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mercersburg, Pa. 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clearspring, Md., R. #1		d. STREET ADDRESS S. Park Ave.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle T. Last SCHAEFFER		4. DATE OF DEATH Month Feb. 21, 1964 Day 19 Year 1964	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1875
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gen. work	
11. BIRTHPLACE (State or foreign country) Mercersburg, Pa., R.D.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Schaeffer		14. MOTHER'S MAIDEN NAME Julia Parrot	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-3355	
17. INFORMANT Mrs. James Scott		Address Mercersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Arteriosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		22. DATE SIGNED 2-22-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/66	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) (State) Mercersburg, Pa.	
24. FUNERAL DIRECTOR ADDRESS Mercersburg, Pa.		25a. REC'D BY REGISTRAR DATE FEB 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Medical Examination

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 10 MINUTES d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 823 PINE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD TRONE SCHINDEL		4. DATE OF DEATH Month Day Year FEBRUARY 2 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY DETECTIVE BUREAU	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME EDWARD SCHINDEL		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-2307	
17. INFORMANT MRS. PHYLLIS SCHINDEL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Howard N. Weeks</i> EXAMINER'S NAME (Type) HOWARD N. WEEKS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 2/2/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/2/1966	
23c. NAME OF CEMETERY OR CREMATORY FUNKSTOWN, CEMETERY		23d. LOCATION (City, town or county) (State) FUNKSTOWN, MARYLAND	
24. FUNERAL DIRECTOR <i>Charles R. Ronger</i> HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR FEB 8 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

100-344

23

WASHINGTON COUNTY HOSPITAL

NAME: JAMES L. WHITE
DOB: JULY 12, 1912
SEX: M
RACE: W
RELIGION: M
MARITAL STATUS: MARRIED

ADMISSION DATE: 7/12/12

ADMISSION TIME: 5:00 PM

ADMISSION PLACE: 100-344

ADMISSION BY: JAMES L. WHITE

ADMISSION REASON: 100-344

ADMISSION STATUS: 100-344

ADMISSION TYPE: 100-344

ADMISSION CLASS: 100-344

ADMISSION FEE: 100-344

ADMISSION CHARGE: 100-344

ADMISSION TOTAL: 100-344

ADMISSION BALANCE: 100-344

ADMISSION DATE: 7/12/12

CERTIFICATE OF DEATH

Reg. Dist. No.

02935

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercersburg,</u> 75-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Conv. Home</u>		d. STREET ADDRESS <u>61 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>WALTER</u> Last <u>SECRIST</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> , Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>	9. AGE (In years last birthday) <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Sylvan, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Secrist</u>		14. MOTHER'S MAIDEN NAME <u>Susan Zimmerman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196-14-4852</u>	
17. INFORMANT <u>Mrs. Harry Sites</u>		Address <u>Mercersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year <u>19</u> a. m. _____ p. m. _____	20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan. 28</u> , 19 <u>66</u> , to <u>Feb. 15</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>66</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>A. W. Ditto</u> M.D. <u>215 W. Washington St.,</u> <u>2-16-66</u> PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/18/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa. (Franklin)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin Liminger</u>		24. REC'D BY REGISTRAR DATE <u>FEB 21 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. PERMANENT RESIDENCE		12. TEMPORARY RESIDENCE	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS	
16. PREVIOUS ILLNESS		17. PREVIOUS SURGERY		18. PREVIOUS TRAUMA	
19. PREVIOUS DRUGS		20. PREVIOUS ALCOHOL		21. PREVIOUS TOBACCO	
22. PREVIOUS RADIATION		23. PREVIOUS CHEMOTHERAPY		24. PREVIOUS HORMONES	
25. PREVIOUS TRANSFUSION		26. PREVIOUS ORGANS		27. PREVIOUS TISSUES	
28. PREVIOUS CELLS		29. PREVIOUS BLOOD		30. PREVIOUS URINE	
31. PREVIOUS SWEAT		32. PREVIOUS SALIVA		33. PREVIOUS TEARS	
34. PREVIOUS SPERM		35. PREVIOUS OVUM		36. PREVIOUS EMBRYO	
37. PREVIOUS FETUS		38. PREVIOUS INFANT		39. PREVIOUS CHILD	
40. PREVIOUS ADULT		41. PREVIOUS ELDERLY		42. PREVIOUS DECEASED	
43. PREVIOUS BURIAL		44. PREVIOUS CREMATION		45. PREVIOUS OTHER	
46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER	
52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER	
55. PREVIOUS OTHER		56. PREVIOUS OTHER		57. PREVIOUS OTHER	
58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER	
64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER	
70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER	
76. PREVIOUS OTHER		77. PREVIOUS OTHER		78. PREVIOUS OTHER	
79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER	
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97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER	

OFFICIAL RECORDS - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

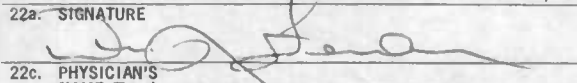
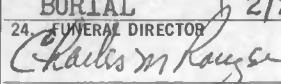
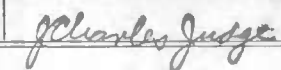
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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02936

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CONOCOCHIEGUE		c. LENGTH OF STAY IN 1b 3 MOS.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GATEWAY CONV. HOME		d. STREET ADDRESS 526 W. CHURCH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SARAH		First JANE		Middle SHANK		Last SHANK		4. DATE OF DEATH Month FEBRUARY	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 4, 1883		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN SOCKS		14. MOTHER'S MAIDEN NAME SARAH YOUNG		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. LELIA SHANHOLTZ	
				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH MINUTES Yes. Yes			
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 Dec. , 19 65 , to 24 Feb. , 19 66 , that (I) (we) last saw the deceased alive on 24 Feb. , 19 66 , and that death occurred at 9:44 A.M. from the causes and on the date stated above.									
22a. SIGNATURE 		M.D. WILLIAM N. FENDER M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/25/1966			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 218 N. POTOMAC ST. HAGERSTOWN, MARYL.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/28/1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) HAGERSTOWN MARYLAND			
24. FUNERAL DIRECTOR 		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 1 1966		25b. REGISTRAR'S SIGNATURE 			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02956

02937

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 55 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 120 Clearview Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle MADILENE Last SHANK		4. DATE OF DEATH Month February Day 19 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 23, 1910
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Lutheran church	
11. BIRTHPLACE (County & State, or foreign country) Huyetts Crossroad, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frisby Spickler		14. MOTHER'S MAIDEN NAME Edythe Mong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-7717	
17. INFORMANT Robert H. Shank, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Metastatic Carcinoma of lung DUE TO (b) Carcinoma of Rt. Breast DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1964 , to Feb 19, 1966 , that (I) (we) last saw the deceased alive on Feb 9 19 66 , and that death occurred at 12 M. from causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman M.D.		22b. DATE SIGNED 2/21/66	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-22-66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 24 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Penna. b. COUNTY Franklin					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown						c. LENGTH OF STAY IN It 3 yrs.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Convalescent Hospital						d. STREET ADDRESS 23 South Carlisle St.					
3. NAME OF DECEASED (Type or print) Daisy Tenley Shives						4. DATE OF DEATH February 16, 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1879		9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housekeeping				11. BIRTHPLACE (County & State, or foreign country) Franklin Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Tenley						14. MOTHER'S MAIDEN NAME Harriett Bally					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 209-36-4742		17. INFORMANT Garlock Convalescent Hospital, Hagerstown, Md					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Failure DUE TO (b) Arterio-Sclerotic Heart Dis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12 Feb 1966 to Feb 16 1966 that (I) (we) last saw the deceased alive on 12 Feb 1966 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE PT WEBSTER						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) PT WEBSTER						22d. ADDRESS GREENCASTLE, Pa					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/20/1966		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				23d. LOCATION (City, town or county) (State) Mercersburg, Franklin Co. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles M. Zimmerman						25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G374 2/2 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02958 CERTIFICATE OF DEATH 02939

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY WASH. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 601 BRIGHTON PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH R. SOUDERS			4. DATE OF DEATH FEB. 18 1966				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/25/1920	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dixon East Shoe Co.		10b. KIND OF BUSINESS OR INDUSTRY Shoe Manuf.		11. BIRTHPLACE (County & State, or foreign country) FRANKLIN Co., PA.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME CALVIN LONG				
14. MOTHER'S MAIDEN NAME BARBARA ROBINSON			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				
16. SOCIAL SECURITY NO. 162-22-3118			17. INFORMANT Gail E. Souders - Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & PLEURAL EFFUSION DUE TO SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Operative Wound Access of Abdomen wound (b) Operative (c) Wound Access of Abdomen wound					INTERVAL BETWEEN ONSET AND DEATH 5 days 6-7 wks.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS - CHRONIC PYELONEPHRITIS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 11 Sept. 1962 , to 18 Feb. 1966 , that (I) (we) last saw the deceased alive on 18 Feb. 1966 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]			22b. DATE SIGNED 19 Feb 1966				
22c. PHYSICIAN'S NAME (Type) W. N. FENDER			22d. ADDRESS 218 N. POTOMAC ST. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/21/66	23c. NAME OF CEMETERY OR CREMATORY Welsh Run Brethren Cem - Welsh Run, Pa.		23d. LOCATION (City, town or county) (State) Pa.			
24. FUNERAL DIRECTOR A. E. Minnich - GREENCASTLE, Pa.		25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 10 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 308 WAKEFIELD ROAD					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 308 WAKEFIELD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROBERT JAMES SPONAUGLE			4. DATE OF DEATH Month FEBRUARY Day 10 Year 1966						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 12, 1921		9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR: Months 44 Days 44 Hours 44 Min. 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY MACK TRUCKS		11. BIRTHPLACE (County & State, or foreign country) CENTRE CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED J. SPONAUGLE					14. MOTHER'S MAIDEN NAME KATHLEEN LIVESAY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWII			16. SOCIAL SECURITY NO. 235-28-3594		17. INFORMANT THOMAS S. WHITE, JR.			HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) years									INTERVAL BETWEEN ONSET AND DEATH Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9 Feb, 1966 , to 10 Feb, 1966 , that (I) (we) last saw the deceased alive on 9 Feb 1966 , and that death occurred at 4 AM , from the causes and on the date stated above.									
22a. SIGNATURE J. Dean Wilson					22b. DATE SIGNED 2/11/1966				
22c. PHYSICIAN'S NAME (Type) J. DEAN WILSON M.D.					22d. ADDRESS 580 NORTHERN AVE, HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE THEREOF FEB. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND		
24. FUNERAL DIRECTOR Charles M. Lougher					25a. REC'D BY REGISTRAR FEB 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02960
CERTIFICATE OF DEATH
02941

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
3. NAME OF DECEASED (Type or print) First <u>Lolita</u> Middle <u>Mae</u> Last <u>Staley</u>		d. STREET ADDRESS <u>10 S. Conococheague Street</u>	
5. SEX <u>Female</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>19 66</u>	
6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>Aug. 27 1915</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Near Williamsport Md. U.S.A</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ernest Reid</u>		14. MOTHER'S MAIDEN NAME <u>Olive May Flora</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 14 2997</u>	
17. INFIRMANT <u>Mr. Joseph Lee Staley Williamsport Md</u>		Address <u>10 S Conococheague St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST & Metastasis</u> <u>170X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/65</u> , 19 <u>65</u> , to <u>2/1/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/1/66</u> , 19 <u>66</u> , and that death occurred at <u>1A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. F. Young</u>		22b. DATE SIGNED <u>2/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>		22d. ADDRESS <u>Williamsport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and must be filed within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02961

CERTIFICATE OF DEATH

02942

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Hillsborough	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN lb 16 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney Keedy Mem. Home		d. STREET ADDRESS 827 Bayshore Blvd.	
3. NAME OF DECEASED (Type or print) First Walter Middle J. Last Staley		4. DATE OF DEATH Month February Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1891
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months 86 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (County & State, or foreign country) Rural Retreat, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Pierson Staley		14. MOTHER'S MAIDEN NAME Virginia Snavelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. One		16. SOCIAL SECURITY NO. 181-26-0754	
17. INFORMANT Mrs. Goldie M. Staley, Boonsboro Rfd. 1, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Coronary Arteriosclerosis DUE TO (c) + Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Instant Indef.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 to Feb 5, 1966 , that (I) (we) last saw the deceased alive on Feb. 5, 1966 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED Feb 6, 1966	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley		22d. ADDRESS 1448 W. Washington St. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-8-66	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR FEB 8 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>	
c. LENGTH OF STAY IN 1b <u>Hours</u>		d. STREET ADDRESS <u>105 Stouffer Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			
3. NAME OF DECEASED (Type or print) First <u>Sherry</u> Middle <u>Ann</u> Last <u>Stottlemeyer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1950</u> 15 yrs.
9. AGE (In years last birthday) <u>15</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Cleatys Sherwood Stottlemeyer</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Ann Haines</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Alice Ann Stottlemeyer</u> Address <u>Funkstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Edema, Left Hemothorax</u> 8124 DUE TO Status Post Pulmonary Laceration And Right (b) <u>Lower Lobectomy</u> DUE TO Fractured 5,6,7,8 Ribs & Fracture Of Right (c) <u>Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While sledding struck by car at street intersection.</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour 1:30 p.m. 2-1- 19 66</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Funkstown, Washington, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>2-3-66</u>	
Address (Street, city, town, or county) <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hout</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Wm. C. Brown
2/2/12

2/2/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Washington</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i> c. LENGTH OF STAY IN 1b <i>38 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington County Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i> d. STREET ADDRESS <i>36 E. Washington St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>Emory</i> Last <i>Strite</i>		4. DATE OF DEATH Month <i>February</i> Day <i>18</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 22, 1905</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance & Assembly</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Aircraft</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Franklin County, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Strite</i>		14. MOTHER'S MAIDEN NAME <i>Rosie McKee</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-09-5084</i>	
17. INFORMANT <i>Mrs. Betty Burger</i>		Address <i>Hagerstown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor. hemorrhage and heart failure</i> DUE TO (b) <i>Ischemic aortic insufficiency</i> DUE TO (c) <i>Terminating illness</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>stroke + cerebrovascular insufficiency</i>			INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>years</i> <i>years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>death</i> , 19 <i>1966</i> , that (I) (we) last saw the deceased alive on <i>Feb. 17</i> , 19 <i>1966</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John C. Stauffer</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>John C. Stauffer M.D.</i>		22d. ADDRESS <i>145 S. Prospect St. Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/21/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>	23d. LOCATION (city, town or county) (State) <i>Hagerstown Md.</i>
24. FUNERAL DIRECTOR <i>Wm. C. Hont</i> ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 23 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

W. C. Carter

4. 11. 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02964 CERTIFICATE OF DEATH 02945

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 133 W. FRANKLIN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CECILIA VIRGINIA SWITZER		4. DATE OF DEATH Month FEBRUARY Day 13 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		9b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	9c. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	10c. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL SWITZER		14. MOTHER'S MAIDEN NAME MARY J. LAWRENCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-4968	
17. INFORMANT WILLIAM H. SWITZER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO General Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs. DUE TO (c) Osteoporosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoporosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 6, 1966 to Feb 13, 1966 , that (I) did last saw the deceased alive on Feb 13, 1966 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE J. H. Beachley		22b. DATE SIGNED 2/14/1966	
22c. PHYSICIAN'S NAME (Type) JACK H. BEACHLEY M.D.		22d. ADDRESS 221 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 16, 1966	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) HAGERSTOWN, MD.
24. FUNERAL DIRECTOR Charles M. Kueper		25a. REC'D BY REGISTRAR FEB 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



STATE OF NEW YORK
IN SENATE
JANUARY 10, 1901
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1901

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1901

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
02965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02946

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY in 1b 1 HR.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS RURAL BOONSBORO RT.#2 BOONSBORO			
3. NAME OF DECEASED (Type or print) LUCINDA MARIA TRACY				4. DATE OF DEATH FEBRUARY 15 19 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/16/1893	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BAKER				14. MOTHER'S MAIDEN NAME LUCINDA JACKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT MRS. DAISY SCHMIDT MD.				18. ADDRESS TAKOMA PARK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4221 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Sudden Yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Howard N. Weeks</i> EXAMINER'S NAME (Type) Howard N. Weeks, M. D.				DATE SIGNED 2/17/66			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/66		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or country) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR <i>W. J. Norment, Hagerstown, Md.</i>				24. REC'D BY REGISTRAR FEB 21 1966			
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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WASHINGTON
NATIONAL BUREAU OF INVESTIGATION
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

RECEIVED
FEBRUARY 12 1963
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

INVESTIGATION
FEDERAL BUREAU OF INVESTIGATION
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WASHINGTON, D. C.
FEBRUARY 12 1963
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

WASHINGTON, D. C.
FEBRUARY 12 1963
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

34 1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02947

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 5 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2105 HILLDALE ROAD		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 2105 HILLDALE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAURINE BARBARA UHL		4. DATE OF DEATH Month FEBRUARY Day 5 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV.	9. AGE (In years last birthday) 45 yrs.
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KELEHER		14. MOTHER'S MAIDEN NAME ANNE SHIPSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT EDWARD UHL 2105 HILLDALE ROAD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pericardial Myocardial fibrosis-Focal, of left 4221 DUE TO ventricle and I-V septum - with Focal (b) DUE TO interstitial myocarditis and small artery (c) sclerosis.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemochromatosis - liver - pancreas - adrenals		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Edward W. Ditto, Jr.</i> EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.		22. DATE SIGNED 2/7/1966	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR <i>Charles R. Langer</i> HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR FEB 11 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Obstruction of small bowel</i> <i>5705</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus & Anterior Arterio Sclerotic Disease</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 13, 1966</i> to <i>Feb 22, 1966</i> , that (I) (we) last saw the deceased alive on <i>Feb 19, 1966</i> , and that death occurred at <i>5:20 AM</i> , from the causes and on the date stated above.										
22a. SIGNATURE <i>Edson B. Moody</i> 22c. PHYSICIAN'S NAME (Type) EDSON B. MOODY M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.		22b. DATE SIGNED 2/22/1966		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEB. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON CO., MD.				
24. FUNERAL DIRECTOR <i>Charles M. Langer</i> HAGERSTOWN, MARYLAND				25a. REC'D BY REGISTRAR FEB 28 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02967 Item 7 Film 0374 2/4/66 mh 02948											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN lb 1 1/2 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CLEARVIEW NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1016 CORBETT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ADA REGINA WAGNER			4. DATE OF DEATH FEBRUARY 22 19 66								
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 18, 1874		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS				10b. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (County & State, or foreign country) FREDERICK CO., MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME IGNATIUS WAGNER					14. MOTHER'S MAIDEN NAME MARY LIVERS WILLIAMSPORT, MD.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-22-2484		17. INFORMANT PAUL WAGNER 18 TAMMANY LANE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park 16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>503 Lincoln Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>George Kieffer Warman</u>		4. DATE OF DEATH <u>Feb. 7, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1914</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B. C. Fireman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Fire Department</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Hyallesville Md</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
14. FATHER'S NAME <u>Frank C. Warman</u>		15. MOTHER'S MAIDEN NAME <u>Ida Kieffer</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>Ms. Catherine R. Warman (same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA LT</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>CEREBRAL THROMBOSIS</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>1 WEEK</u> <u>2 1/2 YEARS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 13, 1965</u> , to <u>FEB. 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB. 7, 1966</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Efren A. Ramirez</u> M.D.		22b. DATE SIGNED <u>3-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EFREN A. RAMIREZ</u>		22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington DC</u>
24. FUNERAL DIRECTOR <u>Sakma Funeral Home Inc. 254 Carroll St NW</u>		25a. REC'D BY REGISTRAR <u>Feb 10 1966</u>	
ADDRESS <u>254 Carroll St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02040

George Kiefer
Magistrate

cc

Feb 2

ACUTE MYOCARDIAL INFARCTION
CIRCULAR THERAPY
EXERCISES

ways of Feb 2

Werner and the woman
Hoffmann, 1942

Feb 2
Werner and the woman
Hoffmann, 1942

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02969
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02950

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. # 1 York 75-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home Inc</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Sallie</u> Middle <u>May</u> Last <u>Weigel</u>		4. DATE OF DEATH		Month <u>Feb</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>York Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Alice Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>199-07-5730B</u>		17. INFORMANT <u>Mable Wagner Williamsport, Md</u> Address <u>2750 Va Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1992</u> DUE TO <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1966</u> to <u>Feb 13, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Feb 10, 1966</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 16 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHILOH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SHILOH W MARCH TWP YORK, PA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Wadsworth</u> ADDRESS <u>New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

ALABAMA STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
CENTRAL DEPT. OF HEALTH

1950

1950

Blank form with horizontal lines for data entry.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02970

02951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Leitersburg		c. LENGTH OF STAY IN 1b hours	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural---Kearneysville 85-3	
		f. STREET ADDRESS RFD # 1	
3. NAME OF DECEASED (Type or print) Edward Taylor Winkler		4. DATE OF DEATH Month February Day 11 Year 19 66	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1900
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Lee Winkler		14. MOTHER'S MAIDEN NAME Ida Mae Whittington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 233-34-3519	
17. INFORMANT Rt. 4, Martinsburg, W.Va.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Coronary Disease	
19. INTERVAL BETWEEN ONSET AND DEATH Instant		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. E. W. Ditto, Jr.</i>		22. DATE SIGNED 2-12-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-15-66	
23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		23d. LOCATION (City, town or county) (State) Charles Town, W. Va.	
24. FUNERAL DIRECTOR Melvin T. Strider Co., Charles Town, W. Va.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>E. Gay Davis</i>		DATE FEB 15 1966	

• Livingston - 1910

3240

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02971 CERTIFICATE OF DEATH 02952									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 2033 VIRGINIA AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT			First Middle Last RENO WOLF		4. DATE OF DEATH Month Day Year FEBRUARY 8 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/1914		9. AGE (In years last birthday) 31 IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST			10b. KIND OF BUSINESS OR INDUSTRY ELECTRIC UTILITY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CAROL WOLF					14. MOTHER'S MAIDEN NAME MYRTLE DRILL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-10-3976		17. INFORMANT MRS PAULINE C. WOLF			Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation + inanition 163x DUE TO (b) Bleeding from bronchial carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Disseminated malignant lung cancer								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/13, 1965, to 2/8, 1966 that (I) (we) last saw the deceased alive on 2/7, 1966 and that death occurred at 2A M, from the causes and on the date stated above.									
22a. SIGNATURE Thomas V. Craig					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/9/66		
22c. PHYSICIAN'S NAME (Type) Thomas V. Craig, M. D.					22d. ADDRESS 247 N. Potomac St.				
23a. BURIAL, CREMATION, REINTERMENT (Specify)			23b. DATE THEREOF 2/11/66		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.					25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal on any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

02972

CERTIFICATE OF DEATH

02953

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro Rfd. 1 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Benevola		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche M. Wyand				4. DATE OF DEATH Month Day Year February 16, 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1896	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 27		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Rural Sharpsburg, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert M. Wyand				14. MOTHER'S MAIDEN NAME Fannie May Burtner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. George Bowman, Waynesboro, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 Arteriosclerosis with DUE TO gangrene of both legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 8 1/2 mos 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 14 , 19 66 , to Feb 16 , 19 66 , that (I) (we) last saw the deceased alive on Feb 16 , 19 66 , and that death occurred at 10 P.M. from causes and on the date stated above.							
22a. SIGNATURE G. Wyand				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-18-66	
22c. PHYSICIAN'S NAME (Type) G. Wyand				22d. ADDRESS Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-19-66		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Keedysville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St., Boonsboro, Md.				25a. REC'D BY REGISTRAR DATE FEB 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02973 CERTIFICATE OF DEATH 02954

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md. d. STREET ADDRESS 160 Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Ethel Yeakle		4. DATE OF DEATH Feb. 16 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1896
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home duties	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael OConner		14. MOTHER'S MAIDEN NAME Cora Mullen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 213-24-8882	
17. INFORMANT John T. Yeakle		Address Clspg. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Myocardium 4201 DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Coronary artery atherosclerosis, severe			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 48 hours unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus...Hypertensive Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 11, 1966 , to Feb 16, 1966 , that (I) (we) last saw the deceased alive on February 16, 1966 , and that death occurred at 4:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED Feb 18, 1966	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/19/66	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery
23d. LOCATION (City, town or county) (State) Washington Co. Md.			
24. FUNERAL DIRECTOR <i>Margaret Rowland</i>		25a. REC'D BY REGISTRAR FEB 23 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Washington County Health Department

Clear Spring, Md.

100 Main St.

Phone 1-280-1111

Dec. 1, 1960

Home Office, Baltimore, Md.

Cora Miller

11-11-60 John T. Yankie, Clear Spring, Md.

Director of the Department

Medical Information

Coronary artery atherosclerosis, atherosclerosis

Disease of the Heart and Blood Vessels

Heart and Blood Vessels

Heart and Blood Vessels

Heart and Blood Vessels

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